I authorize release of my medical records to my referring physician. I authorize Rudi E. Ide & Associates and its physical therapists to release to any guarantor, my employers, insurance company, or the Social Security Administration or its intermediaries, any information required to secure payment for charges incurred by me or on my behalf including diagnosis of my condition. I include in this information any information regarding HIV or AIDS status, substance abuse and psychiatric history.

In the event that my treatment is paid from the PIP portion of my motor vehicle insurance policy, I acknowledge and understand that Rudi E. Ide & Associates and its physical therapists do not accept assignment of PIP benefits from the insurance carrier. I also acknowledge and understand that this agreement shall not be construed by me or my insurer as an assignment of such benefits pursuant to 527,736(5), F.S.

The undersigned and Rudi E. Ide & Associates agree that the sole purpose of this document is to authorize the direct payment of medical bills to Rudi E. Ide & Associates for the convenience of the undersigned patient.

The patient, and all involved, understand that this signature on file revokes all prior dated signatures on file, and they are hereby declared null and void and are substituted by this signature on file, or any other signed this date hereafter.

I hereby agree to pay all charges connected with this treatment, and, if Medicare eligible, even if Medicare does not provide coverage. I understand that I am obligated to begin payment on my portion of the bill immediately.

Signature: _____
Patient- Parent if under 18 or
Legal Guardian

Witness: _____
Date: _____

Signature: _____
Rudi E. Ide & Associates

Witness: _____
Date: _____