

PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC
Patient Registration and Consent for Medical Treatment

1. **Consent for Health Care Services:** I authorize consent for medical treatment at **PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC**
2. **Authorization for Release or Information:** **PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC** may release information from my medical records to any health care provider involved in my care and treatment. **PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC** may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, **PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC** is no longer responsible for the confidentiality of any information known or possessed by the payer.
3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by **PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC** which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If Payment is not made within 90 days from the date the bill was mailed from **PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC**, I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with **PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC**. I understand that I am responsible for a \$25.00 returned check fee in addition to any other associated bank charges.
4. **Preauthorization Requirements:** I accept the responsibility to obtain all referrals or preauthorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of **PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC** charges.
5. **Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to **PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC** charges not paid.
6. **Charge for No Show/Cancellation without 24 hour notice:** I understand that 24 hour notice is required for canceling an appointment, and I will be charged a \$25.00 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be billed for that day.

I acknowledge that:

- **I have read this form and understand its contents.**
- **I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.**
- **I am responsible for the payment and/or co-payment that is due at the time of service.**
- **I have received a copy of *PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC* . HIPAA**

Policy

Signature of Patient or Legally Responsible Person

Name (PRINT)

Relationship/Reason Why Patient is Unable to Sign

Date