ASSIGNMENT OF BENEFITS:

I authorize payment of Medicare/Insurance benefits to be made directly to TheraSport, P.T. on my behalf for my physical therapy services rendered. I also authorize TheraSport P.T. to release my protected health information for the purpose of billing and treatment.

Initials: _____

NOTICE OF PRIVACY PRACTICES :

I have received a written copy of TheraSport's Notice of Privacy Practices. The notice provides, in detail, the uses and disclosures of my protected health information that may be made by TheraSport, my rights as the patient, and TheraSport's legal duties to protect my health information. Initials:_____

FINANCIAL POLICY:

As a courtesy, TheraSport, P.T. will pre-verify your insurance benefits. Please Note: Unless you have a secondary insurance, all **co-pays**, **deductibles,** and/or co-insurance is the patient's/guardian's (in case of a minor) responsibility. **Co-pays** are **due at the time of service**. Your deductible/co-insurance will be billed to you once we have received an "Explanation of Benefits", from your insurance carrier. Initials:_____

*Payment methods include: Cash, checks, money order, Visa, Master-card, Discover. Returned checks are subject to a **$25.00** fee and balances older than 30 days are subject to additional charges,

CONSENT FOR TREATMENT:

I, the undersigned due hereby agree and give my consent for TheraSport Physical Therapy, LLC to furnish physical therapy to myself or dependent, which is considered necessary and proper in evaluating and treating myself or dependent for my/their physical condition. I have read and fully understand the consent.

Initials:_____

SIGNATURE ON FILE:

I have read, understand, and agree with the above policies and procedures.

_____ _____

Patient/Guardian Signature **Date**

_____ _____

TheraSport Staff Member **Date**