TheraSport Physical Therapy

RELEASE OF INFORMATION:

I hereby authorize the release of any information by telephone or in writing, including written reports of diagnosis, treatment, prognosis, recommendations, benefits payable, as well as any other data pertinent to my treatment, by TheraSport Physical Therapy, LLC (TheraSport) to my physician(s), as well as any organization responsible for payment of my account, and any legal representative involved in my litigation. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

Initials: ________

ASSIGNMENT OF BENEFITS:

I hereby authorize that the payment of authorized benefits be made directly to TheraSport for any services that are reimbursable by Medicare, Medicaid, or any Third Party sources.

Initials: _______

CONSENT TO TREAT

I hereby consent to such treatment procedures and patient care which, in the judgement of my therapist and / or physician, may be considered necessary or advisable while I am a patient of TheraSport.

Initials: ________

NOTICE OF PRIVACY PRACTICES:

I have received a 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 / GUARANTEE OF ACCOUNT:

In consideration of services rendered to me by TheraSport, I hereby guarantee payment for any and all services which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I understand that there may be a charge for supplies that are needed during my course of treatment that will not be covered by my insurance and for which I am financially responsible. I also understand that I may have a co-payment, co-insurance and / or deductible, which I am fully responsible for paying. Although TheraSport will inform me of my insurance coverage for physical therapy, it is ultimately my responsibility to understand my insurance benefit limitations and payments. I will notify TheraSport of any changes in my insurance coverage while receiving physical therapy. Returned checks are subject to a **$50** fee.

Initials: ________

CANCELLATION POLICY:

TheraSport Physical Therapy is committed to providing you with excellent, quality physical therapy services. We ask that you make every effort to arrive on time for scheduled appointments. TheraSport Physical Therapy reserves the right to assess a $50 fee for failure to provide 24 hours' notice for appointment cancellations. This fee will be assessed regardless of insurance type and payment is the responsibility of the patient, not the insurance company.

SIGNATURE:

I, ______________________ have read, understand, and agree with the above policies and procedures
(Print Name)

____ ________________________
Patient/Guardian Signature **Date**