ORTHO SPORT
PHYSICAL THERAPY, INC.

Acknowledgement of Ortho Sport Physical Therapy, Inc. Office Policies

The following are Ortho Sport Physical Therapy Inc.'s policies regarding scheduling, payments, and information releases. Please read carefully and be sure to ask for clarification if unsure.

Cancellation Policy: If you miss two appointments without calling or have excessive cancellations, you will be subject to discharge, or a $30.00 fee not covered by your insurance.

Insurance Benefits: All copays are due at the time of each visit. It is the patient's responsibility to know the physical therapy benefits provided by their health insurance including copayments, coinsurance amounts, applied deductibles and visit limits. Failure to notify Ortho Sport Physical Therapy of insurance inactivation may result in patient responsibility.

Payments: By signing this document, I am authorizing my insurance company or attorney to pay Ortho Sport Physical Therapy, Inc. for the professional services rendered. By signing this document, I acknowledge that I understand that I am responsible for the fees my insurance company does not pay on my claims (i.e. copayment, coinsurance, deductibles). I also acknowledge that I agree to pay the full amount of charges should it be that my condition is not covered by my policy or if for some reason my insurance/attorney refuse to pay the balance.

Treatment: By signing this document, I am giving Ortho Sport Physical Therapy, Inc. my permission to evaluate and treat the condition for which I am seeking services. I understand that the clinic and/or gym area are common areas accessed by other patients, gym members, and visitors and that as a result, there may be incidental contact with personal health information.

Release: I am authorizing Ortho Sport Physical Therapy, Inc. to release any pertinent information from my case to my insurance company or attorney to collect payment on my balance accrued at this office.

I certify that I have read and understand all of the office policies listed above.

Signature: _____ Date: _____

Printed name: _____

Witness signature: _____ Date: _____

Witness printed name: _____

ORTHO SPORT PHYSICAL THERAPY, INC.

NOTICE OF PRIVACY AND INFORMATION PRACTICES

In compliance with Federal Law, effective September 23, 2013

By signing this form, I acknowledge that I have reviewed

THIS CONSENT AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES SET FORTH WITHIN THIS AUTHORIZATION

_____ _____

Signature of Patient or Representative Date

_____

Patient's Name

_____

Date of Birth

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient

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*****OFFICE USE ONLY*****

A copy of the completed and signed Authorization form has been provided to the patient or representative:

_____Yes _____No

_____ _____

Signature of Authorized Clinic Representative Date