CONSENT TO TREATMENT

I hereby authorize the professional staff at ***Elite Sports and Physical Therapy*** to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to. I further consent to have my minor child treated by the staff of ***Elite Sports and Physical Therapy*** while I am not physically in the facility.

_____	_____	_____
Patient Name (Printed)	Patient Signature	Date
_____	_____	_____
Parent / Guardian Name (Printed)	Parent / Guardian Signature	Relationship
_____	_____	
Witness	Date	

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: ***Elite Sports and Physical Therapy*** for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that ***Elite Sports and Physical Therapy*** complies with HIPAA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

HIPAA REGULATIONS A photocopy of this Assignment shall be considered effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPAA guidelines.

_____	_____	_____
Patient Name (Printed)	Patient Signature	Date
_____	_____	_____
Parent / Guardian Name (Printed)	Parent / Guardian Signature	Relationship
_____	_____	
Witness	Date	

Elite Sports and Physical Therapy

Please give your permission for Elite Sports and Physical Therapy to provide automatic appointment reminder service by email or by cell phone text message.

Step One: Select **<u>One</u>** Option Below:

- ☐ Elite Sports and Physical Therapy may send **<u>email messages</u>** to confirm my upcoming appointments to: _____
- ☐ Elite Sports and Physical Therapy may send **<u>cell phone text messages</u>** to confirm my upcoming appointments to: _____

Step Two: If you would like text messages instead of email reminders, please indicate your cell phone carrier. Please circle your cell phone carrier, if you would like text message reminders:

AT&T **Verizon** **Sprint** **T Mobile** **Other**: _____

**Normal text messaging rates may apply.*

Emergency Contact Name _____

Emergency Contact Phone # _____

Relationship _____

CANCELLATION POLICY

Should you need to cancel your appointment please note that we require a

24-HOUR ADVANCED NOTICE

We will give you an appointment card to keep track of your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all your appointments; however we understand that there may be times when you cannot contact us and are unable to keep your appointment. If this happens please contact us at your earliest convenience to confirm your next appointment. Should you miss an appointment and not afford us the courtesy of a 24-hour advance notice so we can offer your appointment slot to another patient, **we reserve the right to charge you a fee.**

CANCELLATION FEE: $25.00; NO SHOW FEE: $40.00

If you miss three (3) consecutive appointments we will:
- Notify your physician and will require a new referral in order to continue your treatment
- At the discretion of the physical therapist, you may be discharged from therapy

_____ _____

Patient / Guardian Signature Date

CREDIT CARD POLICY / AUTHORIZATION

Elite Sports, Inc. (d/b/a Elite Sports Performance & Physical Therapy) requires all patients to provide a valid credit card number to be kept on file in a secure and protected location until the conclusion of the patient's episode of care.

Please note that this credit card will only be billed in the event that a patient has any outstanding balances following the conclusion of treatment.

Cardholder's Name: _____

Cardholder's Billing Address: _____

City/Town: _____ **State:** _____ **Zip Code:** _____

Circle Type of Credit Card: **MC** **VISA** **DISCOVER** **AMEX**

☐ **Use Existing Stored Credit Card on File:** _____

Credit Card Number: _____

Expiration Date: _____

I hereby authorize Elite Sports, Inc. to keep my credit card information on file in order to pay any outstanding balances at the conclusion of my treatment. If I am sent a final statement detailing charges owed and I have not made other arrangements to pay the balance within ten (10) days of issue or have not disputed the bill, I grant permission for Elite Sports, Inc. to utilize the payment source provided above to pay off my account.

This form will be kept on file and will remain in effect until the conclusion of treatment and all outstanding balances are paid in full. Applicants must submit a written notification to Elite Sports, Inc. to revoke this form or report the credit card cancelled, lost or stolen.

_____ _____ _____

Patient / Guardian Printed Name | Patient / Guardian Signature | Date

_____ _____

Witness | Date