

ASSIGNMENT AND RELEASE

I certify that all information on the previous page is correct as listed and that myself or my dependant (s), have health insurance coverage as listed on the previous page, and assign directly to AGILITY Spine & Sports Physical Therapy, insurance benefits, if any, otherwise payable to me for services needed. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that I am responsible for my co-payments / co-insurance*, which is due at time of treatment, and any applicable deductible that has not been met. I authorize the use of my signature on all insurance forms. The above named facility (including its' employees) may use my treatment care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

CONSENT FOR TREATMENT / NOTICE OF PATIENT INFORMATION PRACTICE

I, or my representative, recognizing the need for care, consent to all services ordered or deemed appropriate by my physician and or physical therapist. I have received and fully understand the MDR Physical Therapy Inc., dba AGILITY SPINE AND SPORTS P.T. Notice of Privacy Practices. I understand that AGILITY SPINE AND SPORTS P.T. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that AGILITY SPINE AND SPORTS P.T. will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in AGILITY SPINE AND SPORTS P.T.'s notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

CANCELLATION POLICY

At Agility Spine and Sports P.T., we take your time and treatment seriously. It is important to the progression of your treatment that you attend all your appointments. I understand that cancellations WITHOUT 24-hour in advance notice or "no-shows" will be subject to a \$25.00 office fee. Your insurance (even worker's comp) does not cover this fee. I understand that if my insurance company does not cover supplies utilized in my treatment I will be held responsible for them.

I have read and understand all the information provided above. I also understand that I am ultimately responsible for the balance of professional services rendered. All the information I have given to AGILITY is true and correct to the best of my knowledge. I agree to notify AGILITY SPINE AND SPORTS P.T. of any changes of my insurance and information provided.

(PLEASE PRINT PATIENT NAME)

(SIGNATURE OF PATIENT/LEGAL GUARDIAN)

(TODAY'S DATE)

(GUARDIAN NAME)

*Co-insurance is a cost sharing method used by insurance companies. Your insurance company guarantees to pay a percentage of your treatment, and you are responsible for the remainder. We use an estimate to determine your co-insurance amount due. We cannot guarantee that the amount you pay will cover your exact charges from your insurance, and there may be a balance at the end of your treatment. _____

(initials)

*Your policy is subject to a deductible, we agree to apply all monies received in our office to that deductible, but we cannot guarantee that there will not be a balance remaining from your insurance. We encourage you to contact your insurance company directly if you have any further questions beyond our explanation. _____

(initials)