AUTHORIZTION/ACKNOWLEDGEMENT OF POLICIES AND RESPONSIBLITIES
READ CAREFULLY INITIAL AND SIGN BELOW

AUTHORIZTION TO RELEASE MEDICAL INFORMATION: **INITIAL** ___________

I authorize release of medical information necessary to process this (these) insurance claim (s) and permit the following to be used in place of this original document for all federal, state, commercial, compensation, or liability insurance claims:

1. a photo copy of other facsimile reproduction of this authorization, *or*
2. use of a computer to indicate my signature is on file at clinic, *and/or*
3. use of a computer to electronically transmit my claim for processing.

AUTHORIZTION TO ASSIGN MEDICAL BENEFITS TO CLINIC: **INITIAL** ___________

I certify that information provided relative to injury, illness, and insurance coverage is both true and correct. I authorize payment of insurance benefits or proceeds from any liability claim and legal/court settlement to be assigned to the physicians of this Clinic to the extent that their charges are paid in full. I authorize my insurance benefits be paid directly to Champions Recovery Room and Physical Therapy for services rendered.

ACKNOWLEGEMENT OF PATIENT FINANCIAL OBLIGATION AGREEMENT **INITIAL** ___________

I acknowledge I have received and I understand “Patient Financial Obligation Agreement” that all applicable copayments and deductibles may be collected upon check-in for each visit. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I understand that patient/patient’s family is responsible to pay all fees accrued, regardless of insurance verification or anticipated insurance coverage. I understand all insurance plans are different and its impossible for Champions Recovery Room and Physical Therapy to know the specifics of my insurance plan(s) and/or if my plan will reimburse for services received. I agree to pay all fees within 30 days after bill has been mailed. In the event of a returned or invalid payment, as well as an unpaid balance over 90 days, I agree to pay any and all additional associated costs of banking, legal, and/or collections fees.
I understand that I am ultimately responsible for payment of all services received. I understand I am advised to fully know and understand my insurance benefits prior to receiving physical therapy services. I agree to pay all fees accrued for services received.

ACKNOWLEDGEMENT OF INSURANCE LIMTATIONS: **INITIAL** ___________

Many insurance carries require a written referral from a primary care physician (PCP) in advance of services (office visits, surgery, and diagnostic tests – MRI). Patients, parents, or the guardians are responsible for (1) obtaining physician referrals and (2) contacting their insurance carrier to verity benefits in advance of service. Patients are also responsible for non-covered services, deductibles, co-insurance, and any penalties imposed by their insurance company on our physician for seeing patients out-of-network. Co-payments are due at the time of service.

ACKNOWLEDGEMENT OF CANCELLATION POLICY: **INITIAL** ___________

I acknowledge to arrive on-time for my scheduled appointment. I will call and notify Champions Recovery Room and Physical Therapy if the patient is going to be late. If patient is going to be more than 15 minutes late the appointment will have to be rescheduled. I acknowledge if I am late to a scheduled appointment, I may receive a shortened physical therapy session. I understand my scheduled appointment will be marked as a “no-show” if we do not receive 24 hours in advance of a cancellation. *“No-show” will be charged a $45 “no-show” fee. Same day cancellations may be charged a $45 cancellation fee at the therapist discretion.* After three “no-show” appointments, patient will be removed from all scheduled appointments and placed on a “call” list. When another client cancels, patient will be offered that physical therapy appointment.

ACKNOWLEDGEMENT OF PAYMENT RESPONSIBILITY: **INITIAL ___________**

Payment for medical services is between the Clinic (physician) and the patient. Payment is due in full according to the terms of this Clinic's credit policy. Therefore, I understand that this Clinic cannot accept responsibility for collecting or negotiation settlement on any (1) health insurance claim, (2) workers' compensation claim, (3) accidental injury illness liability claim, (4) claim where patient is/will be represented by an attorney, and/or (5) claim to be settled in a court of law.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: **INITIAL ___________**

I understand I have a right to review Champions Recovery Room and Physical Therapy Notice of Privacy Practices prior to signing this document. Champions Recovery Room and Physical Therapy Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describe s the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Champions Recovery Room and Physical Therapy. The Notice of Privacy Practices for Champions Recovery Room and Physical Therapy is also in the clinic registration area and on Champions Recovery Room and Physical Therapy website at http://championsrecoveryroom.com/. This Notice of Practices also describe my rights at Champions Recovery Room and Physical Therapy duties with respect to my protected health information.

Champions Recovery Room and Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Champions Recovery Room and Physical Therapy website, calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment. Champions Recovery Room and Physical Therapy accepts VISA, MASTER CARD, or Cash.

Signature of Patient or Personal Representative ______________________________________ Date ______________

Name of Patient or Personal Representative ____

Description of Personal Representative's Authority/ Relationship to Patient _____________________________________