ASSIGNMENT OF BENEFITS:

I authorize payment of Medicare/Insurance benefits to be made directly to TheraSport, P.T. on my behalf for my physical therapy services rendered. I also authorize TheraSport P.T. to release my protected health information for the purpose of billing and treatment.
Initials: _____

NOTICE OF PRIVACY PRACTICES :

I have received a written 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:

As a courtesy, TheraSport, P.T. will pre-verify your insurance benefits. Please Note: Unless you have a secondary insurance, all co-pays, deductibles, and/or co-insurance is the patient's/guardian's (in case of a minor) responsibility. Co-pays are due at the time of service. Your deductible/co-insurance will be billed to you once we have received an "Explanation of Benefits", from your insurance carrier. Initials:_____

*Payment methods include: Cash, checks, money order, Visa, Master-card, Discover. Returned checks and balances older than 90 days are subject to additional charges,

CANCELLATION/NO-SHOW POLICY:

TheraSport, P.T. requires you to keep every scheduled appointment, as consistent treatment is beneficial to your recovery. We require 24 hours notice if you need to cancel an appointment. TheraSport, P.T. reserves the right to discharge a patient, with proper written notice, if a patient does adhere to this policy. Initials:_____

SIGNATURE ON FILE:

I have read, understand, and agree with the above policies and procedures.

_____ _____
Patient/Guardian Signature Date

_____ _____
TheraSport Staff Member Date