Spine & Sport
PHYSICAL THERAPY

REGISTRATION AGREEMENT

NOTICE OF PRIVACY PRACTICES - Spine & Sport Physical Therapy (SSPT) understands that information about your health, health care and payment for health care is personal and confidential, and we are committed to safeguarding that information. Further, your health information is protected by state and federal laws and regulations. SSPT has a Notice of Privacy Practices that outlines the ways in which we may use and disclose your personal health information. It discusses your rights and certain obligations we have regarding the use and disclosure of your protected rights. The undersigned acknowledges that a Notice of Privacy Practices has been made available to all patients and that patients may request a personal copy of the Notice of Privacy Practices. ______ ***Initial***

RELEASE OF INFORMATION – SSPT may disclose any or all parts of my medical records to business associates such as 3rd party billing services and to my insurance carrier(s) and/or any organization(s) contractually responsible for charges billed for services rendered at SSPT. In addition, I authorize SSPT to disclose any or parts of my medical records to any organization(s) for the purpose of arranging continuing care deemed necessary. ______ ***Initial***

MEDICAL CONSENT – The undersigned consents to treatment and procedures which may be performed during the physical therapy session(s) at SSPT. As a patient, I have a right to know the identity and credentials of those providing patient care, to refuse any treatment, and to be informed of the possible medical consequences of refusal. My signature on this document indicates my General Consent to be treated. My therapists and/or members of SSPT may request that I sign a more specific form relative to any treatment that may be performed. ______ ***Initial***

FINANCIAL RESPONSIBILITY – In consideration of services and materials provided by SSPT, the undersigned agrees to be responsible for payment in full at the time of service. <u>If your insurance company does not pay your claim in full, or if your insurance company pays only a portion of your claim, the undersigned is fully responsible for the full or remaining outstanding balance.</u> In the event that any unpaid accounts are turned over to an attorney or agency for collection, the undersigned shall pay one hundred percent (100%) of the attorney's fees and all other legal fees and collection agency costs pertaining to this encounter. Payment by the patient of his/her portion of the bill (co-payments, coinsurance, and deductible) is due at the time of each visit. If you choose not to have your claims filed by our office, full payment is due at the time of each treatment rendered. ______ ***Initial***
In the event a personal check bounces due to insufficient funds, the undersigned agrees to resubmit payment with an additional $20 fee.

ASSIGNMENT OF BENEFITS – The undersigned hereby authorizes SSPT to apply for benefits on my behalf for services rendered at SSPT and request that all payments are to be made directly to Spine & Sport Physical Therapy. I certify that the information I have reported about my insurance coverage is correct. I also authorize SSPT to release all necessary information including medical information for this and any related claim in order to determine benefits for which I am entitled. I permit copy of this authorization to be used in place of the original. ______ ***Initial***

REMINDER PHONE CALLS – We may use and disclose information in your medical record to contact you as a reminder that you have an appointment. We usually will call you at home the day before your appointment and leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we call you only at a certain number or that we refrain from leaving messages and we will endeavor to accommodate all reasonable requests. ______ ***Initial***

CANCELLATION POLICY – If you are unable to keep an appointment, please contact our office 24 hours before your scheduled appointment time so we may offer that appointment time to other patients. **A fee will be charged for any no call/no show occurrences, cancellations without 24-hour advance notice, and late arrivals [twenty (20) or more minutes following your scheduled appointment time].** See fees below:

- ***First (1st) and second (2nd) Late Cancellation/Late Arrival*: $10**
- ***Third (3rd) and any additional Late Cancellation/Late Arrival*: $25**
- ***<u>ALL</u> no call/no show appointments: $25***

______ ***Initial***

Patient Signature: ____ **Date:** ____________________

Patient Name: ____

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