PRO IMPACT
PHYSICAL THERAPY • SPORTS PERFORMANCE

Patient Authorization

Patient Name:	Date of Birth:

RELEASE OF INFORMATION & CONSENT FOR TREATMENT

All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at this Pro Impact Physical Therapy & Sports Medicine clinic. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Pro Impact Physical Therapy & Sports Performance and its subsidiaries and affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize Pro Impact Physical Therapy & Sports Performance and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

I consent for medical photographs to be made of me (or my child or person for whom I am a legal guardian). I understand that the information may be used in my medical record. By consenting to these medical photographs I understand that I will not receive payment from any party (Pro Impact nor patient). Refusal to consent to photographs will in no way affect the medical care I will receive. The signature below certifies that I have read and understand the above information.

Initial: _____

ASSIGNMENT OF BENEFITS

I authorize payment directly to Pro Impact Physical Therapy & Sports Performance, its subsidiaries and/or affiliates for services and to bill and release payment directly to Pro Impact Physical Therapy & Sports Performance, its subsidiaries and/or affiliates for any physical therapy, occupational therapy, speech-language pathology, rehabilitation, orthotic or prosthetic services provided.

This is a direct assignment of my rights assistive device benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial: _____

NOTICE OF PRIVACY PRACTICES (HIPAA ACKNOWLEDGEMENT/CONSENT)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Pro Impact Physical Therapy & Sports Performance, its subsidiaries and /or affiliates.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operation.

Initial: _____

Patient or Guardian Signature:	Date:

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PAYMENT GUARANTEE

I agree to pay Pro Impact Physical Therapy & Sports Performance, its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as workers' compensation, or an insurance contract prohibit payment for these services I will cooperate and assist in the provision of information and authorizations, released, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

Pro Impact files your insurance as a courtesy but you are still financially responsible. The Eligibility and Benefit form provided by ***some*** insurance companies is only an explanation of coverage. This is not a guarantee of payment by the insurance company. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, **I will be responsible for payment of all services**.

If arbitrary determination of a participating insurance company indicates that a treatment or procedure is not medically necessary, the patient or patients guarantor will be responsible for the remaining balance. **However, it is ultimately the responsibility of the patient or patient's guarantor to know and understand their benefits prior to starting physical therapy.**

FINANCIAL AGREEMENT: I fully understand that I am responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for court costs, attorney fees, and collection fees of up to 33% of the amount due, incurred in the collection of any balance due. I give permission to Pro Impact and any of Pro Impact's vendors, which include collection agencies, attorneys and billers, to contact me on the cell phone numbers I have provided on matters related to my account. I understand that an automated dialer may be used to contact me by these parties and agree to allow them to do so.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Pro Impact Physical Therapy & Sports Performance and/or its affiliates or subsidiaries.

I understand that three statements will be generated in the course of an outstanding balance. After which, a final notice prior to collections will be mailed. Payment in full is expected on outstanding balances. If a payment plan is absolutely necessary, the terms and conditions will be determined by Pro Impact Physical Therapy and Sports Performance owner, not upon the financial plan determined by the client. I further understand and agree that, in addition to all amounts owed for services, which I will be responsible for all costs of collection including, but not limited to, attorney's fees, court cost, filing fees, and any other costs associated with or related to collection efforts instituted by Pro Impact Physical Therapy.

Initial: _____

Patient or Guardian Signature:	Date: