CONSENT FOR CARE & TREATMENT

I agree and give my consent for ANB-PTSMA Holdings Inc, doing business as ***Physical Therapy and Sports Medicine Centers (PTSMC),*** to provide medical care and treatment that is considered necessary and proper in diagnosing or treating my physical condition.

RELEASE OF INFORMATION - FINANCIAL RESPONSIBILITY

I authorize Physical Therapy and Sports Medicine Centers, to release all information necessary, including medical records, to secure payment. I authorize ***PTSMC*** to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to ***PTSMC*** from my insurance carrier or third party payer.

I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between ***Physical Therapy and Sports Medicine Centers*** and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third-party payer. I agree to inform PTSMC immediately if my insurance benefits change, including a change in carrier or benefits. I understand that I am responsible for balances as a result of my failure to inform PTSMC of a change in benefits. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

I acknowledge that there will be an additional $45.00 fee for any checks returned to ***PTSMC*** for insufficient funds. I further acknowledge that there will be a 15% charge added to any delinquent balance that is my responsibility and requires the services of an outside collection agency.

I understand that the above may not apply if I am covered by Worker's Compensation insurance. I understand that if my Worker's Compensation claim and Worker's Compensation benefits are subsequently denied I may be held responsible for the total amount of charges for services rendered to me.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had full opportunity to read the ***PTSMC*** Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to ***PTSMC*** to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and ***PTSMC*** will always post the current notice at the clinic, on the website and have copies available for distribution.

Indicate below who *PTSMC* may speak to regarding your treatment. Please list name and phone number.
Name _____
Phone # _____

Do we have your permission to leave a confidential message at the phone number you provide us?
☐ **Yes - Phone #** _____
☐ **No**

SIGNATURE for CONSENT

By my signature below I acknowledge that I have read, understand, and agree to the terms and conditions contained in this consent form including:

Consent for Care and Treatment
Consent to Release of Information and Financial Responsibility
Consent for Use and Disclosure of Health Information
Consent that I have received an electronic copy of the Notice of Privacy Practices*

Patient (Age 18 or older) or Parent /Guardian_____

Date: _____

**If you wish to receive a paper copy of the Notice of Privacy Practices please request one from the front desk staff.*