SPINE& SPORT
PHYSICAL THERAPY

217 N. 2nd E
Rexburg, ID 83440
208.359.6127
fax 208.359.9479

Patient Name _____ **Patient Guardian:** _____

Notice of Privacy Rights
I acknowledge that I have been presented with a copy of *Spine & Sport Physical Therapy's Notice of Privacy Rights*.

Consent for Assessment & Treatment
I request the clinical staff of Spine & Sport Physical Therapy to provide me with necessary medical assessment & treatment.

Assignment & Release
I hereby authorize my insurance benefits to be paid directly to Spine & Sport Physical Therapy, and I am financially responsible for non-covered services. I also authorize Spine & Sport Physical Therapy to release any information required to process this claim.

Authorized Signature _____ **Date** _____

Medicare Patient Signature Authorization
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Spine & Sport Physical Therapy for any services furnished to me by Spine & Sport Physical Therapy. I give permission to the holder of medical information about me to release to the Health Care Financing Administration and its agents for any information needed to determine these benefits payable for related services.

Authorized Signature _____ **Date** _____

Financial Policy
Thank you for choosing and trusting us with your therapy. We strive to provide the best care available. Please let us know if there is anything we can do to make your visit better.

We require that you pay your co-pays, deductibles, and other payments due at the time of service. We realize that you may be coming in for multiple visits until your therapy is complete. Therefore, at Spine & Sport Physical Therapy, we are flexible and offer multiple options for payment. Please ask our office manager for a payment option that will work for you.

Promise to Pay
I agree to pay my account in full at the time of services, unless before services are performed Spine & Sport Physical Therapy agrees to other payment arrangements. I understand that Spine & Sport Physical Therapy will submit insurance benefits for payment only as a courtesy for me. I agree to pay in full non-covered services. I agree to pay 18% interest on the outstanding balance of my account with interest to commence 60 days after services even if payment from my insurance company is pending. I also agree to pay an additional service charge of 50 cents per month on my account. If Spine & Sport Physical Therapy assigns my account to a collection agency for collections, I agree to pay all reasonable costs and attorney's fees incurred to collect my account. I agree that a $20.00 collection fee shall be added to my account as a reasonable cost if Spine & Sport Physical Therapy assigns my account to a collection agency. I agree to pay as a reasonable attorney's fee $350 or 35% of the principal and interest on my account balance, whichever is greater, if my account is assigned to a collection agency and suit is filed to recover payment on my account.

Payment Options
Please circle a payment option: Check Cash Credit Card

I have read/understand and agree to Spine & Sport Physical Therapy's Financial Policy

Authorized Signature _____ **Date** _____