Sports Motion Physical Therapy

Enhances Motion & Prevents Injury

TERMS AND CONDITIONS OF MEDICAL SERVICE & CONFIDENTIALITY OF INFORMATION

READ CAREFULLY BEFORE SIGNING

PRIVACY PRACTICE/RELEASE INFORMATION:
Upon inquiry. The Clinic may make available to individuals who ask for the patient by name certain basic information about the patient found in the facility directory/schedule including name, patient ID number, the location at which you are receiving care, appointment type reason for the visits, date/time of visits. If the patient or the patient's representative does not want such information to be released, he/she must make a written request for such information to be withheld. The patient or the patient's representative may obtain a separate form for this purpose upon request at the Medical Records Department. The undersigned agrees that, to the extent necessary to coordinate the patient's health care or to determine liability for payment and to obtain reimbursement. The Clinic may disclose portions or all of the patients record as minimally necessary, including his/her medical records and billing information, to any such person or corporation which is or may be liable for all or any portion of the clinics charges, including but not limited to insurance companies, health care service plans, governmental agencies, or workers' compensation carriers.

PERSONAL VALUABLES:
Clinic shall not be liable for the loss of or damage to any money, jewelry, furs, fur coats and fur garments, or other articles of unusual valuable and small size. The clinic shall not be liable for loss or damage to any personal property unless deposited for safekeeping.

FINANCIAL AGREEMENT FOR CLINIC AND PROFESSIONAL SERVICES:
The patient shall pay Sports Motions Physical Therapy for services, in accordance with the regular rates and terms of the Clinic. When a spouse or the financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individually liable with the patient. Should an account(s) be referred to an attorney or a collection agency for collection, the undersigned shall pay the actual attorney's fees (including cost) and collections expenses incurred in addition to other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral. Any unpaid balance on your account that is not paid within 30 days will be charged finance charges at the rate of 1.5% per month (18% annually).

ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS):
The undersigned authorizes, whether he/she signs as agent or as a patient, the direct payment to Clinic of any insurance benefits (including but not limited to insurance and unemployment compensation Disability benefits) otherwise payable to or on behalf of the patient for services, including emergency services if rendered, at a rate not to exceed the clinic's actual charges. It is agreed that payment to the clinic, pursuant to this authorization, by the undersigned that he/she is financially responsible and personally guarantee payment for charges not paid pursuant to this assignment. The patient further certifies that information given in applying for payment under the Medicare or Medi-Cal Programs is correct. The patient requests that payment of authorized benefits be made on his/her behalf to the Clinic.

_____ _____

(SIGNATURE OF INSURED, AUTHORIZED, GUARANTOR) **(DATE)**

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(IF MINOR, STATE RELATIONSHIP TO PATIENT) **(DATE)**