A)

Patient Agreement in Office Policies

"Our financial policy has been set up to prevent misunderstandings"

- I hereby agree to assign payments over to Rochester Sports & Physical Therapy II if my insurance carrier pays me directly for physical therapy services rendered to this facility.
- I realize that I am responsible for payment for any or all physical therapy treatments that my insurance carrier does not pay.
- **I am responsible for my $__________ co-payment which has been determined by my HMO insurance. My co-pay will be paid at the time of service, unless other arrangements have been made with the office.**
- I understand that a $20 fee will be charged for all returned/bad checks and will terminate my privilege to pay by check on future visits.
- I understand and agree that in the event any outstanding balance has to be referred to a collection agency or attorney for recovery, I will be responsible for all collection and attorney's fees.
- Because your time is valuable, we will make every effort to begin promptly. However, our time is equally as important and we expect that you be on time for scheduled appointments and give us 24 hours notice of any cancellation. A $15 charge may be charged to patients who cancel without 24 hour notice.

Please sign below to indicate that you have read and fully understand this policy.

____ ______________________

Signature Date

B)

Authorization and Consent

I, ____hereby give Rochester Sports & Physical Therapy my consent to inform my insurance company, doctor's office, family members/friends of my choice and case manager, if applicable, of my physical therapy progress and share protected health information for billing purposes. This includes phone conversations, faxes, progress reports, and doctor's prescriptions. In addition, I give my consent to allow Rochester Sports & Physical Therapy to receive copies of relevant doctors' reports, diagnostic reports (X-Ray, MRI, etc.) and records of previous treatments for my current diagnosis. This authorization is in effect from my first physical therapy evaluation/treatment and continues for one calendar year. Additionally I would like to following people listed below to receive my physical therapy notes/records: *(Please list names AND relationship*)

I have the right to revoke this authorization at any time by sending written notification to Rochester Sports & Physical Therapy, 1564 Long Pond Rd., Rochester, NY 14626. I understand that the revocation is not effective to the extent that Rochester Sports & Physical Therapy has relied on the use or disclosure of the protected health information. I also have the right to inspect or copy the protected health information to be used as permitted under federal law or state law to the extent the law provides greater access rights.

Signature____Date______________________

C)

Medicare Patients Only

I certify that the information given me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its carriers, any information required to process my Medicare claims. I request that payment under the medical insurance program be made either to me or to Rochester Sports & Physical Therapy for services provided to me during the period__________________to____________________.