CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for ANB-PTSMA Holdings Inc, doing business as ***Physical Therapy and Sports Medicine Centers*** to furnish medical care and treatment to ____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY- RELEASE OF INFORMATION

I authorize ***Physical Therapy and Sports Medicine Centers*** to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to ***Physical Therapy and Sports Medicine Centers*** 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 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.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

A photocopy of this authorization is to be considered as valid as the original.

By my signature, I authorize Physical Therapy and Sports Medicine Centers, to release all information necessary, including medical records, to secure payment.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had full opportunity to read the ***Physical Therapy and Sports Medicine Centers*** Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to ***Physical Therapy and Sports Medicine Centers*** 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 ***Physical Therapy and Sports Medicine Centers*** will always post the current notice at the clinic, on the website and have copies available for distribution.

Indicated below are individuals whom ***Physical Therapy and Sports Medicine Centers*** may speak to regarding my treatment. Please list names.

- ☐ spouse __________________________________ ☐ father ____
- ☐ mother __________________________________ ☐ other ____

By my signature below I acknowledge that I have read, understand and agree to the terms and conditions contained in the ***Consent for Care and Treatment***, the ***Authorization*** to release all information necessary to secure payment and the ***Consent For Use and Disclosure of Health Information.***

Patient / Guardian/Responsible Party Signature: ____ **Date** __________________