

ELITE SPORTS MEDICINE AND PHYSICAL THERAPY

CONSENT FOR CARE AGREEMENT

● I, the undersigned, do hereby agree and give my consent for Elite Sports Medicine and Physical Therapy to furnish medical care and treatment to, _____, considered necessary and proper in diagnosing or treating his/her physical condition.
(name of patient)

ASSIGNMENT OF BENEFITS AGREEMENT

● I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medigap, Medicaid, private insurance and third party payers to Progress Rehabilitation Network LLC, dba Elite Sports Medicine and Physical Therapy.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACTION

Patient/Guardian _____ Date _____

Printed Name: _____

Relationship to Patient: _____

FINANCIAL POLICY STATEMENT

If you have health care benefits, Progress Rehabilitation Network, LLC dba Elite Sports Medicine and Physical Therapy will submit a claim to your insurance company on your behalf and allow no less than 60 days for the insurance company to respond. However, you are required, and you agree, to pay at time of service any required co-payments and deductibles, as well as charges for any services not covered by insurance, outstanding balances, and delinquent accounts. For your convenience, we accept cash, checks and credit/debit cards. By signing this document, you acknowledge that your insurance company may determine that the services provided are not covered under your insurance policy and agree that, if your insurance company determines that any services are not covered, you shall be responsible for, and shall pay, the cost of any such services. **Initial** _____

If you do not have health care benefits, you are required, and you agree, to pay at time of service, all charges as well as any outstanding balances and delinquent accounts. Patients that elect to be "Self Pay" are expected to pay at time of service.

If you pay by check, and your check is dishonored or returned for any reason, we will expect payment in full plus a returned check fee of \$50.00 within 30 days of the returned check. **Initial** _____

If any debt is owed to Elite Sports Medicine and Physical Therapy and is referred to an attorney or collection agency for collections, I agree to pay all attorney and collection fees in the amount of thirty-three percent (33%) of the total indebtedness, including all court costs and filing fees incurred by Elite Sports Medicine and Physical Therapy. I understand and agree that should Elite Sports Medicine and Physical Therapy be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1 1/2%) per month or eighteen percent (18%) per annum, beginning on the date of judgment. **Initial** _____

Under the assignment of benefits agreement above, if any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same amount to Elite Sports Medicine and Physical Therapy/Progress Rehabilitation Network, LLC **Initial** _____

Insurance

We do our best to verify your plan benefits with your insurance company as a courtesy to you. However, benefits that we are quoted by your insurance company are not a guarantee of payment. Actual benefits are determined by your insurance company at the time the claim is processed. Co-pays will be collected at the time services are rendered. When payment from your insurance company is received, we will know then if we have to modify your co-pay. If you have a co-insurance, a deductible, or any other "Patient Responsibility" as determined by your insurance company, a bill will be sent to you with payment due upon receipt.

Worker's Compensation

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

Cancellation/No Show Policy

If you need to cancel an appointment, kindly provide at least 24 hours notice so that we may offer that time to another patient. Failure to provide 24 hours notice of need to cancel an appointment, or failing to appear for a scheduled appointment (No Show) will result in a \$35.00 charge.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE FINANCIAL POLICY STATEMENT

Guarantor: _____ Date _____

Guarantor Printed Name: _____

Relationship to Patient: _____