

AUTHORIZATION FOR TREATMENT

___Permission is hereby given to the Sports & Rehab Clinic to render treatment and procedures they deem necessary for medical care to the patient whose name appears on this form. The person(s) signing this form has read and understands the above authorization.

The person(s) signing this form also understands and certifies that no guarantee or assurance has been made as to the results that may be obtained by agreeing to such treatments and procedures as may be exercised.

PAYMENT GUARANTEE

___I will be responsible for and guarantee payment of the portion of the Sports & Rehab Clinic's bill not covered by insurance or other government programs which may result from this admission.

AUTHORIZATION TO PAY INSURANCE BENEFITS

___I hereby authorize payment directly to the Sports & Rehab Clinic, benefits herein specified and otherwise payable to me, but not to exceed the Clinic's regular charges for the date(s) of the Clinic's service listed below. I also authorize payment directly to physicians who provide consultative services as a result of the Clinic's services provided for the date(s) of the Clinic's service listed below.

AUTHORIZATION TO RELEASE INSURANCE INFORMATION

___I authorize the Sports & Rehab Clinic to release information requested by my insurance company or government program for the processing of the Clinic's bill.

I authorize the Sports & Rehab Clinic to release claim information requested by my employer for processing workers comp claims.

I authorize the Sports & Rehab Clinic to release claim information to my employer if my employer's insurance plan requires my employer to submit my claims directly to the insurance plan.

ACCEPTANCE OF RESPONSIBILITY FOR COST OF COLLECTION

___It is also understood and agreed by the patient or responsible party that the person responsible for payment or services received shall be responsible for all costs of collection and/or attorney and court costs in the event such charges are referred to a collection agent outside the Sports & Rehab Clinic.

Date _____ Time _____ P.M./AM

Signed _____
(Patient)

Witness _____ or _____
(Authorized person)