You must be 18 years or older in order to sign the following authorizations

AUTHORIZATION TO TREAT:

I hereby authorize Sports Medicine Inc., d/b/a Orthopedic Physical Therapy, ***to evaluate and treat*** me/my minor child with those modalities and procedures recommended by my/his/her physician and physical therapist. I also understand that my treatment may include the use of equipment and facilities at The Body Shoppe Health and Fitness Center and consent to allow continued treatment in that environment.

AUTHORIZATION TO PAY BENEFITS:

I hereby authorize my insurance carrier to make payment directly to Sports Medicine Inc. d/b/a Orthopedic Physical Therapy for all services rendered.

OBLIGATION TO PAY:

I understand that ***I am financially responsible*** for any charges not covered by my insurance, as well as any deductible, coinsurance or copayment required by my insurance plan.

APPOINTMENT REMINDERS – PLEASE *CIRCLE* YOUR PREFERENCE:

Phone Calls Phone # _____

Or **Text Messages** **Cell #** _____ **Carrier** _____
*Standard Text Messaging Rates May Apply

Or Email Email Address _____

OBLIGATION TO OBTAIN REFERRAL:

I understand that it is my responsibility to obtain all necessary orders or referrals, and that failure to do so will result in my personal financial obligation.

OBLIGATION TO NOTIFY US OF PRIOR TREATMENT:

I understand that I am responsible for any services denied if I have failed to notify Sports Medicine Inc. d/b/a Orthopedic Physical Therapy of treatment rendered elsewhere.

I have had other physical therapy services in 2018 ***NO YES Where:*** _____

PRIVACY POLICY:

I have viewed a copy of Sports Medicine Inc. d/b/a Orthopedic Physical Therapy's Notice of Privacy Practice.
Would you like a copy? Circle ***YES or NO*** If yes, please ask for one at reception desk.

I HAVE READ AND AGREE TO THE ABOVE:

_____

Print patient name

_____

Signature of patient (or parent if a minor child) **date**