PREMIER PHYSICAL THERAPY
& SPORTS PERFORMANCE

In Partnership with Fallon Physical Therapy

WELCOME

We are pleased that you have selected Premier Physical Therapy & Sports Performance (PPT) for your rehabilitative care and physical therapy needs. Our goal is to relieve your pain and have you functional again in as short of time as possible, but physical therapy is a process and based upon your diagnosis and current status, this process may take a few days or a few months. Please let us know how we can serve you best since you are the reason why Premier Physical Therapy & Sports Performance was founded. We hope you enjoy your time with us as we dedicate ourselves to helping you reach your full recovery potential.

Please fill out the attached forms legibly, accurately and completely. This information will be held in strict confidence in accordance with all current HIPAA requirements and is essential to ensure your understanding of our billing procedures, our determination of your physical therapy diagnosis, and our development of your complete, individualized, functional plan of care. You have access to your records upon request at any time (subject to record retention regulations). We will require five to ten business days to comply with any records request.

The Premier Physical Therapy Team

Premier Physical Therapy & Sports Performance

In Partnership with Fallon Physical Therapy

Commitment Agreement

All of us at Premier Physical Therapy & Sports Performance are dedicated to providing you with high quality care and are excited about the opportunity to help you with your recovery. Education and experience enable our therapists to be sensitive to your specific needs and abilities and then adapt our interventions accordingly. Our physical therapy programs employ a balanced blend of manual therapy and functional/corrective therapeutic exercise specially designed to help you reach your specific goals by minimizing your pain and maximizing your recovery potential.

Physical therapy is a process much like taking antibiotics; once you start you need to finish the regimen before stopping the intervention to maximize your benefit and to minimize your chance of re-injury or flare-up. This process can take a few days or even a few months (dependent upon condition) for optimal results to be achieved and it takes dedication by both you and your PPT team to ensure maximum benefit. We have committed ourselves to you and ask that in return you will dedicate yourself to:

- Schedule appointments according to your doctor's prescription or therapist's discretion.
- Be consistent in your attendance by not missing scheduled appointments.
- Be dedicated to your home exercise program and self-treatment so that you can achieve the best possible result.

To assist you in your commitment, we offer lunch hour appointments, extended hours, and a willingness to adjust our schedule times to better serve you and your busy lifestyle. We are here to help you achieve optimal results, so please let us know how we can better serve you along the way.

Please sign below to verify your commitment to the process of physical therapy and dedication to your individualized program, as it is the most vital part in achieving the best result.

Consent for Physical Therapy Services

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid patients in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery.

You acknowledge that your therapist has (a) explained the treatment protocol which is planned for you based on your individual history, physical therapy diagnosis, symptoms, and examination results; (b) explained the potential risks and benefits, including the possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury; and (c) answered any questions to your satisfaction.

Since responses to physical therapy interventions vary from person to person, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. PPT does not guarantee what your reaction will be to any specific treatment, nor does it guarantee that the treatment will help resolve the condition for which you are seeking physical therapy. It is very important to communicate with your treating physical therapist throughout your treatment should you feel any discomfort or pain or have other unresolved concerns. Depending on your responses to the planned treatment protocol, your therapist may need to change

or adjust your treatment plan. Your therapist will explain any new or changed treatments, including the potential risks and benefits, before the treatment is provided.

I have read this consent form and understand my planned treatment and the risks involved in physical therapy. I agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care, subject to my right to decline any treatment at any time before or during such treatment.

_____	_____	_____
Patient Signature	Patient Name	Date

Premier Physical Therapy & Sports Performance (PPT)

In Partnership with Fallon Physical Therapy

Patient Information

Please print all information in the spaces provided. Be sure to complete all applicable information.

Last Name _____ First Name

_____ M.I_____

Preferred Name _____ ▫ Male ▫ Female DOB _____ SS#

_____

Status: ▫ Married ▫ Single ▫ Widow(ed) ▫ Divorced ▫ Minor Spouse/Partner Name:

_____

Address _____Apt#_____City

_____ST_____Zip_____

Home Number ( )_____ Work Number ( )_____ Cell

( )_____

Email Address _____

What is your preference for receiving communications from PPT?

▫ *Text #* _____ ▫ *E-Mail* _____ ▫ *Phone Call #*_____ ▫*None*

How did you hear about/referred to PPT?

_____

Referring Doctor: _____

Primary Care Physician: _____

Name and phone # of contact in case of an emergency

_____

FACILITY INFORMATION (if applicable): **Skilled Nursing Facility** ▫ YES ▫ NO **Assisted Living** ▫ YES ▫ NO **Other** ▫ YES ▫ NO

Facility Name and Address:

_____

MEDICAL DECISION MAKING & FINANCIALLY RESPONSIBLE PERSON (if not patient):

[ ] **Parent of Minor Patient** [ ] **Guardian** [ ] **Power of Attorney** [ ] **Other** (please specify): _____

Please provide documentation to verify relationship to patient.

Name: _____

Address: _____

DOB (D-M-Y): _____ Phone: _____

Is the person listed above financially responsible for the patient? □ Yes □ No If no, please provide information below.

Name: _____

Address: _____

DOB (D-M-Y): _____ Phone: _____

Premier Physical Therapy & Sports Performance (PPT)
In Partnership with Fallon Physical Therapy
Insurance Information

Have you ever been treated for this injury in the past or have you made a claim under workers comp or an auto accident for this injury? ☐ **YES** ☐ **NO**

Primary Insurance
Insurance Company
Insurance Phone # _____ Employer
Claims Address
Name of Insured _____ DOB _____ Relationship to Patient
Insured ID # _____ Group Number _____

Secondary Insurance
Insurance Company
Insurance Phone #
Claims Address
Name of Insured DOB
Insured ID # _____

If injury is a Workers Comp case or through a Lien, please complete the following:

Is your injury job related? **YES NO** Date of injury _____ Claim #
If YES: Employer Name_____ Employer Phone #_____
Is your injury due to a Premises Liability? **YES NO** Date of injury _____ Claim #
Is your injury due to an Assault? **YES NO** Date of injury _____ Claim #
Is your injury due to a Battery? **YES NO** Date of injury _____ Claim #
Insurance Company (if applicable) _____Phone #
Name of Adjuster (if applicable)_____Phone #
Attorney (if applicable) _____Phone #

Assignment of Benefits: I hereby authorize release of any medical information necessary to process my insurance claim and assign to PPT all payments from Medicare and/or other applicable insurance provider(s) for services rendered.

_____ _____

Signature of Patient or Patient Representative Date

_____

Printed Patient Representative Name and Relationship to Patient

Premier Physical Therapy & Sports Performance (PPT)

In Partnership with Fallon Physical Therapy *Please Read & Initial All…*

_____ **Cancellation Policy** We request that, when possible, you give us 24-hour notice if you need to cancel an appointment. We are flexible and understand that situations beyond our control do arise. We will work with you to get your appointment rescheduled without penalty if you call us 24 hours prior to your appointment time. By initialing, you acknowledge that it is at our discretion to charge you a fee of $85 if you "no call, no show" an appointment.

_____ **Financial Policy** I understand and agree that I am financially responsible for all charges for services provided to me, including payment of all deductibles, copayments, coinsurance, and any balance not covered and/or not paid by applicable insurance benefits (including without limitation any out-of-network charges if PPT does not participate with my insurance). I understand that my payment portion is due and will be collected at the time services are rendered. If I am the parent/guardian of a minor patient, then I agree that I am responsible for payment of any treatments or services provided to the minor patient. I understand that charges and potential insurance benefits quoted to me are only an estimate. I understand that it is my full responsibility to know and understand my health plan. I understand that PPT is not responsible for any inaccurate information they receive from my insurance company. I understand that it is my responsibility to obtain necessary referrals from my doctor prior to coming to PPT, if required by my insurance. I also agree to pay any additional charges incurred, including without limitation (i) $25 for any returned checks; (ii) charges for copying and distribution of patient medical records; and (iii) charges for form preparation/completion.

_____ **Claims submission** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

_____ **Collections** Any outstanding balance after 90 days of the date of service may be referred to an outside collection agency. Should collection proceedings or other legal action become necessary to collect an overdue/delinquent account, you understand that PPT has the right to disclose to an outside collection agency/attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that you received treatment at our offices, may become a matter of public record.

_____ **Confidentiality** All financial transactions and personal data are handled and maintained with strict confidentiality in accordance with HIPAA requirements; provided, however, that I authorize the release of any medical information necessary to process any insurance claim.

_____ **Coverage Changes** I will notify PPT prior to my next visit of any change in my insurance to allow time for prior authorization and to obtain coverage information. Failure to provide this notice may result in you being responsible for the full charges up to the date you inform PPT of the change in insurance.

_____ **Payment Options** PPT accepts payment by cash, check, major credit cards (Visa, MasterCard, and Discover) and debit cards. PPT also offers the option to keep a credit card on file with us. When you pay by credit card to be held on file, you agree to keep the credit card information current, and you authorize PPT to securely store your credit card information and charge it should you have an outstanding balance or any leftover balance for any future services you receive.

_____ **Personal Valuables/Dependents/Visitors** It is understood and agreed that PPT is not responsible for loss or damage to any personal valuables or properties. In order to maximize safety, if children are present, please keep them off the exercise equipment in order to prevent injuries. There may be exceptions; please ask if you have any concerns or questions. We will do everything possible to accommodate your schedule if you are a caretaker of small children.

_____ **Authorization** If applicable, I authorize PPT to have full disclosure of any settlement agreement or disbursement sheet from any attorney or insurance adjuster regarding the injury for which I am seeking treatment.

_____
_____
Signature of patient or legal guardian/representative **Date**

Premier Physical Therapy and Sports Performance (PPT)
Medical History

Federal regulations require a medical history to be included in your medical chart. This information also allows PPT to tailor a treatment plan specific to your needs, consider how your overall health might affect your recovery, and identify any precautions we need to take during treatment in order to ensure your safety. it is safe for you. Please use the back of the page if more space is needed.

Patient Name: _____ Date: _____

Date of injury/surgery: _____

Chief complaint: _____

When did this problem start? _____

Have you noticed anything which makes your symptoms worse or better?

_____

Have you received any therapy/treatments *this* year, such as chiropractic, physical, occupational, or speech therapy? □ YES □ NO If yes, was it for this injury? □ YES □ NO

If you have *ever* received physical therapy treatment (for *any* injury), were you satisfied with the outcome? Anything you want us to know?

_____

Did a physician make a recommendation or referral for you to receive physical therapy for this injury?

□ YES □ NO If yes, please provide the following information:

Doctor Name: _____ Address: _____

Phone: _____ Fax: _____

Do you have (or have you ever had) any of the following? Please circle all that apply.

Diabetes	Yes	No	Sensitive Heat/Ice	Yes	No
High Blood Pressure	Yes	No	Currently Pregnant	Yes	No

Heart Disease	Yes	No	Other Allergies	Yes	No
Heart Attack	Yes	No	Previous Surgery	Yes	No
Pacemaker	Yes	No	Hernia	Yes	No
Headaches (chronic)	Yes	No	Seizures	Yes	No
Kidney Problems	Yes	No	Metal Implants	Yes	No
Nervous Disorders	Yes	No	Cancer	Yes	No
Visual/hearing Impairments	Yes	No	Peripheral Neuropathy	Yes	No
Numbness	Yes	No	Tingling	Yes	No

If any are "yes," any additional information or explanation:

_____

___

Other health condition(s) past or present:

_____

Do you have any allergies? If so, please list:

_____

List all relevant surgeries:

_____

Are you presently taking any medication(s) or other drug(s), including prescription, over-the-counter, vitamins, supplements, or recreational? □ YES □ NO

Medication/Drug Name	Dosage/Frequency	Reason or Condition
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____

Do you use marijuana (recreationally or medically)? □ YES □ NO If yes, how much?

_____

Do you smoke tobacco? □ YES □ NO If yes, how much? _____

Do you drink alcohol? □ YES □ NO If yes, how much? _____ drinks per day/week/month (circle one)

Patient Primary Care Doctor:

Doctor Name: _____ Address: _____

Phone: _____ Fax: _____

The above information is correct and complete to the best of my knowledge, information and belief

_____	_____
Patient Signature	Date

Premier Physical Therapy & Sports Performance

In Partnership with Fallon Physical Therapy

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I was provided with an opportunity to review the Notice of Privacy Practices that describes how my protected health information is used and disclosed and that a copy of the Notice of Privacy Practices was made available to me at the time of check-in.

PATIENT

_____ _____

Printed Name (Last, First Middle) **Date of Birth**

_____ _____

Signature of individual or representative **Date**

_____

If representative, relationship to patient (parent, guardian, etc.)

OFFICE USE ONLY

If patient declines to sign, staff should document below:

I provided the Notice of Privacy Practices to the patient or his/her Legally Authorized Representative on this date.

_____ _____

Name and Title **Date**

Premier Physical Therapy & Sports Performance

In Partnership with Fallon Physical Therapy

Medical Information Release Form
HIPAA Authorization Form

Name: _____Date of Birth: _____/_____/_____

We are unable to disclose/discuss your treatment/account information with anyone unless you give us written permission.

[ ] I authorize the release of information including the diagnosis, records, examination and treatment rendered to me, any claims/statement information, and any other Protected Health Information to upon the request of the following (mark any which are applicable):

[ ] Spouse Name: _____
[ ] Child(ren) Name(s): _____
[ ] Parent Name: _____
[ ] Other Name: _____
[ ] Information is not to be released to anyone.

This authorization will remain in effect until (choose and initial one):

_____ Terminated by me in writing; or _____ The following date: _____

[ ] I agree that in order for PPT to service my account, collect any amounts I may owe, or obtain any other information regarding my treatment (including but not limited to appointments, insurance information, health care information, and/or balance forwards, etc.), PPT may contact me by text, email, or other electronic communication using any telephone number(s) and email included in my PPT records.

Messages

Please reach me by [ ] home [ ] work [ ] cell/text [ ] email [ ] all

Number _____

Email:_____

If unable to reach me:
[ ] You may leave a detailed voice mail message/email/text containing my Protected Health Information
[ ] Please leave a message/email/text asking me to contact you
[ ] Other_____

The best time to reach me is (day) _____ between (time) _____.

Signed: _____Date: _____/_____/_____

Premier Physical Therapy & Sports Performance
In Partnership with Fallon Physical Therapy

A BRIEF LOOK AT ARBITRATION FOR THE PATIENT[1]

Introduction

Arbitration is an alternative dispute resolution procedure that has been endorsed by such groups as the California Medical Association and noted to be a favored method of resolving disputes by the United States Supreme Court.

If you are unfamiliar with arbitration in general the information included here provides some of the basic principles of arbitration.

What is arbitration?

Arbitration is an alternative way of resolving disputes. Instead of taking your disagreement through the long and expensive process of court litigation, *you* and PPT[2] agree in advance to submit any disputes to an arbitrator for his or her determination. The arbitrator is selected from among the numerous retired judges who are available and qualified "to serve on these matters, and is mutually agreed upon by both you and PPT. After the arbitration hearing, which is usually less formal than a court proceeding, the arbitrator makes the decision ("award"). Although the procedures are different, generally. the same laws and same measure of damages which apply in court proceedings also apply in arbitration.

Does arbitration prevent you from making* a *claim?

No. By selecting arbitration as the means to resolve a disagreement, all you are essentially doing is moving the claim to a different forum (i.e., from a jury to an arbitrator) to hear and ultimately decide your claim.

Does it prevent you from obtaining a financial award?

No. Arbitration does not restrict or prevent you from obtaining a financial award in any manner. If the arbitrator accepts and agrees with your claim he will determine a damage award.

The United States Supreme Court has, in fact, previously held that arbitration is strongly favored as an expeditious and economical alternative to the court system.

May I be represented by an attorney of my choice?

Yes. Any party to arbitration may be represented by an attorney of his or her choice, at his or her own expense. The arbitrator will hear the facts and decide the matter whether or not the parties are represented by lawyers.

Who is ***bound by this agreement?***

If you choose to sign the arbitration agreement, you will be agreeing to bind yourself and anyone who could bring suit in connection with treatment or services provided to you by PPT. If you sign on behalf of a family member or some other person for whom you have responsibility, you will bind that person as well as anyone who could ·sue in connection with treatment or services provided to that person by PPT. Likewise, PPT or anyone suing on behalf of PPT is bound.

What does arbitration cost?

In general, arbitration is less expensive than court actions. The arbitrator's fees are· ordinarily shared equally by the parties. The amount of those fees will depend upon the complexity and length of the case.

If ***either party does not like the arbitration result, could there still be* a *jury trial in court?***

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[1] © Premier Physicians Insurance Company

[2] References to PPT also include individual physical therapists employed by PPT.

Generally, the answer is "no". The whole purpose of arbitration is to avoid the expense, delay and inconvenience of going to court. Arbitration awards may be reviewed and potentially *reversed* ("vacated") by a court in limited circumstances.

A Message to Our Patients About Arbitration

The attached contract is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the physical therapy services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and providers of health care services. Arbitration agreements between health care providers and their patients have long been recognized and approved by the courts.

By signing this agreement, you are substituting an arbitrator for a jury to resolve your claims. You can still call and question witnesses, present evidence, and have an attorney of your choice, at your expense. This agreement generally helps to lower litigation time and costs for both patients and providers. Further, both parties are spared the rigors of a trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

ARBITRATION AGREEMENT

Article I: Agreement to Arbitrate: It is understood that any dispute as to professional negligence/malpractice (i.e., whether any physical therapy services rendered under this contract were unnecessary, unauthorized, or were improperly, negligently or incompetently rendered) will be determined by submission to arbitration as provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are voluntarily giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of binding arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified therapist or physical therapy company, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Therapist") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient'' herein shall mean both the mother and the mother's expected child or children.

Filing by Therapist of any action in any court to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Therapist, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A notice or demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Therapist, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator to preside over the matter who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statutes (NRS) 38.206 - 38.248, 41A.03S, .045, .097, .100, .110, .120, 42.005 and .021 and the Federal Arbitration Act (9 U.S.C. §§ 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The.

parties shall bear their own costs, fees and expenses, along with a pro rata share of the arbitrator's fees and expenses, and hereby waive the provisions of NRS 38.238.

Article 4: Revocation: This agreement may be revoked by written notice delivered to Therapist within 30 days of signature and if not revoked will govern all physical therapy services received by the patient.

Article 5*:* General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if assessed in a civil action, would be barred by the applicable Nevada statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the Nevada Arbitration Rules. In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with Nevada and federal law.

Article 6: Condition of Treatment: I understand that signing this arbitration agreement is not a condition of my receiving physical therapy treatment.

Article 7: **Retroactive Effect**: If the patient intends this agreement to cover services rendered before the date it is signed, the patient should initial directly below and this agreement will be considered effective as of the date of the first physical therapy services:

_____ Patient's or Patient Representative's Initials

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE PROVIDING SPECIFIC AUTHORIZATION TO HAVE ANY ISSUE OF MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

____ INITIAL HERE TO INDICATE THAT YOU HAVE BEEN GIVEN THE DOCUMENT ENTITLED "A BRIEF LOOK AT ARBITRATION FOR THE PATIENT."

_____ _____
Signature of Patient or Patient Representative Date

_____
Printed Patient Name

_____
Printed Patient Representative Name and Relationship to Patient (if applicable)

_____ _____
Signature of Therapist or Authorized Representative Date

_____ _____
Signature of Premier Physical Therapy & Sports Performance Date

(Authorized Representative)

Patient Health Questionnaire

Patient Name_____ **Date**_____

1. **Chief Complaint** _____

_____

A. **Date of Injury/Surgery** _____

B. **Have you ever had an X-ray, CT Scan or MRI of this injury?** □ YES □ NO
If YES, have you or your physician sent us a copy of the report? □ YES □ NO

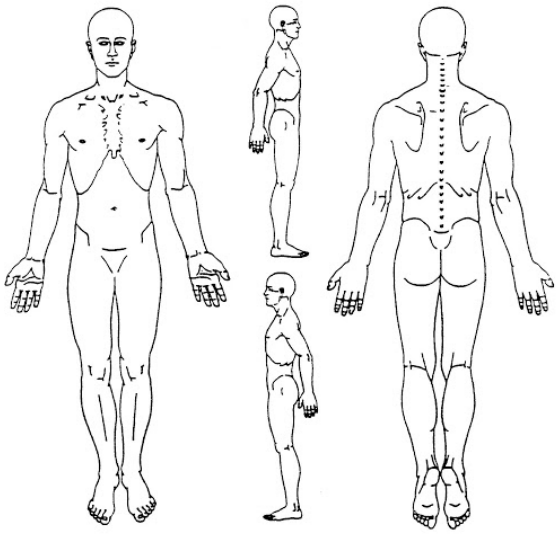
X-rays Date_____ B. MRI Date_____ C. CT Scan Date _____

C. In general, would you say your overall health right now is….

1. Excellent 2. Very Good 3. Good 4. Fair 5. Poor

2. **How often do you experience your symptoms? Indicate where you have pain or other Symptoms:**

A. Constantly (76-100% of the day) B. Frequently (51-75% of the day)
C. Occasionally (26-50% of the day) D. Intermittently (0-25% of the day)



3. **What describes the nature of your symptoms?**
A. Sharp B. Dull Ache C. Numb D. Shooting E. Burning F. Tingling

4. **How are your symptoms changing?**
A. Getting Better B. Not changing C. Getting Worse

5. **During the past 4 Weeks, indicate the average intensity of your symptoms?**

None Unbearable
0 1 2 3 4 5 6 7 8 9 10

_____ _____

CREDIT CARD ON FILE POLICY

At Premier Physical Therapy & Sports Performance we require keeping your credit or debit card on file as a convenient method of payment for the portion of services for which you are liable. Co-pays are still due at time of service. At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. Your credit card information is kept confidential and secure and payments to your card may be processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

By signing below, I authorize Premier Physical Therapy & Sports Performance to charge the portion of my bill that is my financial responsibility and/or all amounts owned to Premier Physical Therapy & Sports Performance to the provided credit or debit card including but not limited to (i) amounts agreed to as part of a payment plan, (ii) copayments, (iii) coinsurance , (iv) deductibles. I authorize Premier Physical Therapy & Sports Performance to charge my credit card or debit card for any outstanding balances when due.

I may not be provided with advance notice of payment authorized hereunder for transactions. I understand that I will receive an emailed and/or mailed statement at the beginning of the month

and if I am in disagreement with any amount I should contact the billing office immediately. After 15 days, if the amount remains unpaid, we will bill your credit card,

This authorization relates to all payments not covered by my insurance company for services provided to me by Premier Physical Therapy & Sports Performance.

I understand that my signature and payment information will be maintained on file for future use by Premier Physical Therapy & Sports Performance. The applicable payment card or bank account number may be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information.

I understand that I am ultimately responsible for payment of charges for services I receive from Premier Physical Therapy & Sports Performance including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.

If the credit card that I provide today changes, expires or is denied for any reason, I agree to immediately give Premier Physical Therapy & Sports Performance a new, valid credit card which I will allow them to charge over the telephone. Even though Premier Physical Therapy & Sports Performance is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification to Premier Physical Therapy & Sports Performance in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____