PROACTIVE
PHYSICAL THERAPY & SPORTS REHAB

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge receipt of ProActive Physical Therapy and Sports Rehab Notice of Privacy Practices.

_____ _____
Patient or Legal Guardian Signature Date

_____
Patient or Legal Guardian Name (please print)

CONSENT FOR TREATMENT & INSURANCE INFORMATION RELEASE

I consent to the therapy rendered to me (or the person for whom I am legally responsible) that is determined to be necessary by the therapist.

I authorize you to speak to _____ (name), _____ (relationship) regarding my account and/or treatment.

I authorize ProActive Physical Therapy and Sports Rehab to contact me via cell phone and/or email regarding appointments or billing inquiries.

Cell phone: ☐ YES ☐ NO
Email: ☐ YES ☐ NO
Permission to leave voicemail: ☐ YES ☐ NO

I authorize ProActive Physical Therapy and Sports Rehab to release any information in the course of my examination and treatment as is required for reimbursement or may be otherwise requested by my insurance carrier, health maintenance organization, other health plan or insurance company representatives/agents. I request my insurance carrier to pay benefits on my behalf to ProActive for any services rendered that are not paid at time of service. I am responsible for the entire bill or balance as determined by ProActive and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services. **I also understand that ProActive Physical Therapy and Sports Rehab collects copayments at time of service.**

As a courtesy to you, ProActive Physical Therapy and Sports Rehab will bill the insurance carrier listed above. Payment obligation is not contingent on any settlement, claim, judgment, or verdict and we do expect full payment.

_____ _____
Signature of Responsible Party Date