Integrated Sports Medicine and Physical Therapy, LLC
An Affiliate of Progress Rehabilitation Network, LLC

CONSENT FOR CARE AGREEMENT

- I, the undersigned, do hereby agree and give my consent for Progress Rehabilitation Network, LLC, d/b/a Integrated Sports Medicine and Physical Therapy, LLC ("Clinic") 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 benefits to include major medical benefits to which I am entitled, including Medicare, Medigap, Medicaid, private insurance and third party payers to the Clinic.

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 insurance, the Clinic will submit claims to your primary and secondary insurance carriers 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 any outstanding balances, delinquent accounts, and any charges for services not covered by insurance. 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. It is your responsibility to notify the Clinic of any changes in your insurance coverage. ***Initial*** _____

If you do not have health insurance or are receiving a non-covered service, 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 within 30 days of the returned check. ***Initial***_____

I acknowledge that balances older than 90 days may be assessed an 18% annual percentage rate (APR) finance charge (1.50% per month).
If any debt is owed to the Clinic 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 the Clinic. I understand and agree that should the Clinic 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, or to an attorney acting on your behalf, for services billed by us, you recognize your obligation to promptly remit the same amount to the Clinic. ***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. If your insurance has not processed claims for services provided to you within 60 days, we reserve the right to bill you directly for the balance in full, at which time you will be responsible for following up with your insurance carrier.

☐ **Worker's Compensation**
The above does not apply to those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation 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 charge.

☐ **Form Completion**
Our fee for completing various types of forms (e.g. Disability Forms) on your behalf is $30 per form. Payment of this fee is due from you prior to releasing the completed forms. Please allow five to ten business days to receive completed forms.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE FINANCIAL POLICY STATEMENT

Guarantor: _____ Date _____

Guarantor Printed Name: _____ Relationship to Patient: _____