PEAK PERFORMANCE
PHYSICAL THERAPY & SPORTS TRAINING

RELEASE OF INFORMATION

All information provided herein is true and correct. I hereby consent to treatment. I give permission to **Peak Performance Physical Therapy & Sports Training** to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.
I authorize Peak Performance Physical Therapy & Sports Training to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment. Information without patient identifiers may be used for quality assurance purposes. I have read and understand the above release.

PATIENT/GUARDIAN SIGNATURE: **DATE:**

ASSIGNMENT OF BENEFITS

I authorize payment directly to **Peak Performance Physical Therapy & Sports Training** for services. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

PATIENT/GUARDIAN SIGNATURE: **DATE:**

PAYMENT GUARANTEE

I agree to pay **Peak Performance Physical Therapy & Sports Training** for the services provided me or the party named above. If any law, such as workers' compensation or insurance contract, prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

Peak Performance Physical Therapy & Sports Training verifies insurance benefits as a courtesy to me as a patient. The verification is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Peak Performance Physical Therapy & Sports Training.

PATIENT/GUARDIAN SIGNATURE: **DATE:**

NOTICE OF PRIVACY PRACTICES (HIPAA ACKNOWLEDGEMENT)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices from **Peak Performance Physical Therapy & Sports Training**.
In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

PATIENT/GUARDIAN SIGNATURE: **DATE:**

CANCELLATION POLICY

We reserve the right to charge a $25 cancellation/no show fee if your appointment is not cancelled with 24-hour notice. This charge is not reimbursable by your insurance company. We understand that circumstances beyond your control may arise and will take them into consideration.

PATIENT/GUARDIAN SIGNATURE: **DATE:**