STRIVE
PHYSICAL THERAPY & SPORTS REHABILITATION

Patient Authorization and Guarantee

IMPORTANT: PLEASE READ THIS CAREFULLY

RELEASE OF INFORMATION

I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by Strive Physical Therapy & Sports Rehabilitation, LLC (SPT) to my physician(s), as well as any organization responsible for payment of my account, and any legal representative involved in my litigation. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

ASSIGNMENT OF INSURANCE BENEFITS

I herby authorize that the payment of authorized benefits be made directly to SPT for any services that are reimbursable by Medicare, Medicaid, or any third party sources.

CONSENT TO TREAT

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of SPT.

GUARANTEE OF ACCOUNT

In consideration of services rendered to me by SPT, I hereby guarantee payment for any and all services rendered to me which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I understand that there may be a charge for supplies that are needed during my course of treatment that will not be covered by my insurance and for which I am financially responsible. I also understand that I may have a co-payment, co-insurance and/or deductible, which I am fully responsible for paying. Although SPT will inform me of my insurance coverage for physical therapy, it is ultimately my responsibility to understand my insurance benefit limitations and payments. I will immediately notify SPT of any changes in my insurance coverage while receiving physical therapy.

MEDICARE

I herby certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

I, __________________, by signing this document, acknowledge my consent to the above:
(Print Name)

Signature: _____________________________________ Date: _________________

Acknowledgement of Receipt of Privacy Notice

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment, or healthcare operations, is made pursuant to the requirements of 45 CFR $164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledged that I am consenting to the use and/or disclosure of personally identifiable health information about me by Strive Physical Therapy & Sports Rehabilitation, LLC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in details the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the Office of the Practice at the following address: 701 East Gate Drive, Suite 304, Mount Laurel, NJ 08054. Attention: Privacy Officer.
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment of healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction, it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

____

I understand the foregoing provisions, and I wish to sign this Acknowledgment authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDEGMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

____
Signature of Patient or Representative Date

____
Patient's Name Date of Birth

____
Name of Personal Representative (if applicable)

____
Relationship to Patient

____
To Be Completed by the Practice

The requested restrictions on the use and /or disclosure of the patient's health information set forth above are:

___________ Accepted ___________ Denied ___________ Not Applicable ___________ Other (explain)

____
Signature of Authorized Practice Representative Date

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Appointment Reminder Consent

Complete this form and sign below to give your permission for Strive Physical Therapy to provide an automatic appointment reminder service by email or text message.

Step One: Select Option Below

- Strive Physical Therapy may send email messages to confirm my upcoming appointments to

  ____

- Strive Physical Therapy may send cell phone text messages to confirm my upcoming appointments to

  ____

  (I recognize normal text messaging rates apply)

- I decline notification

Step Two: If you would like to receive text message confirmation of your upcoming appointments please indicate your cell phone service provider.

We cannot set up your account to receive text message reminders without knowing your cell phone carrier. Please indicate your carrier below.

- ALLTel
- AT&T
- Boost Mobile
- Cingular
- Cricket Wireless
- MetroCall
- MetroPCS
- Nextel
- Qwest
- Sprint PCS
- T-Mobile
- US Cellular
- Verizon
- Virgin Mobile

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Signature of Patient/Parent or Guardian Date