PATIENT AUTHORIZATION, CONSENT, & FINANCIAL POLICIES

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of this Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, policies, or your responsibility.

Your insurance contract is between you and your carrier. As a courtesy to you we will submit your claims to the insurance company. However, if we do not receive payment within 60 days, you will be held responsible. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurances, etc other than to supply factual information as necessary to pay a claim.

**Co-pays and deductibles are due at time of visit.** If writing a check or paying by credit card, please be sure to put the patient’s name on it so it will be properly credited to their account. Please check with your individual policy for any deductible, co-pay, and/or member co-insurance you may be responsible for.

If your case is in litigation, you are nonetheless required to pay the full fee for services that you receive at our office. Receipts for payments will be provided for your lawyer and/or your insurance company. In the event of claim denial or fraud, you will become financially responsible for all treatment charges.

Auto accidents: PIP (Personal Injury Protection) application must be submitted before we can administer treatment. **If PIP is exhausted and there is no other insurance available, patient is responsible for balance.**

“I hereby request and authorize my insurance company or companies to pay directly to Comprehensive Physical Therapy, P.C. any proceeds under the terms of my policy or policies. I understand that any unpaid balance, co-pays, deductibles, and/or member co-insurance is my obligation and will be paid by me. I understand that I am also responsible for any added costs resulting from collection efforts (court costs, interest, legal fees, etc).”

Patient: ______________________________________

Parent/Guardian (If under 18): ________________________________

Signed: ___________________________________ Date: __________________________

“I consent to be evaluated and treated by Comprehensive Physical Therapy, P.C. I give my consent/authorization to Comprehensive Physical Therapy, P.C. to disclose/release my medical records and or billing records to my physician(s’) and insurance company. I know I will have to sign the proper documentation in order for my medical records or bills to be disclosed to anyone else. I am aware that my billing information may be electronically submitted to my insurance carrier. I have read and I am aware of ‘The Patient’s Bill of Rights’.”

Patient: ______________________________________

Parent/Guardian (If under 18): ________________________________

Signed: ___________________________________ Date: __________________________
Patient Appointment Reminder Agreement

Patient Name ________________________________________

(Choose one)

Text message reminders □
Cell Phone #: ____________________________
Service Carrier: ____________________________

Email reminders □
Email address: ____________________________

I would like to receive email or text message appointment reminders. I understand that standard text messaging rates through my service carrier may apply to my account, and will be paid by me.

Signed: ________________________________________ Date: ____________________________
Comprehensive Physical Therapy, P.C.
1037 Main Street
Leicester, MA 01524
(508) 892-1335

23 Ware Street
West Brookfield, MA 01585
(508) 867-0180

Consent for Use and Disclosure of Protected Health Information

Purpose of Consent

This Consent for the use and/or disclosure of personally identifiable health information is made pursuant to the requirements of 42 C.F.R. §164.506, which sets out 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 acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Comprehensive Physical Therapy, P.C. (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 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 detail the way in which the Practice will make such use or disclosure. By signing this Consent, I understand and acknowledge that I have the right to review the Privacy Notice prior to signing this Consent.

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:

   Comprehensive Physical Therapy, P.C.,
   1037 Main Street
   Leicester, MA 01524
   Attention: Practice Compliance Director

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 or 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 request the following restrictions be placed on the Practice's use
5. I understand and acknowledge that I may revoke this Consent at any time by sending a written revocation to the Practice at the address set forth in (3) above. However I also understand and acknowledge that if I revoke this Consent, my revocation will not be effective to the extent that the Practice has already acted in reliance on this Consent.

I understand the foregoing provisions, and I wish to sign this Consent 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 THIS CONSENT AND AGREE TO THE PRACTICE’S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

____________________________________  ____________________________
Signature of Patient or Representative  Date

______________________________________________________________
Patient's Name

______________________________________________________________
Date of Birth

______________________________________________________________
Social Security Number

______________________________________________________________
Name of Personal Representative (if applicable)  Relationship to Patient

** I authorize my protected health information to be disclosed to:

Name: ________________________________  Relationship: ________________________________

Emergency Contact Only:

Name: ________________________________  Phone Number: ________________________________

Relationship: ________________________________
PATIENT NAME

MEDICATION LIST

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