**Missed Appointment Initials: \_\_\_\_\_\_\_\_\_**

You are required to notify the office a minimum of 12 hours in advance if you are unable to make your appointment. If you fail to notify the office in advance and do not show up for your scheduled appointment, you will be charged a “No Show” fee of $50.00. The first “No Show” is a courtesy, then charges will start accruing at $50.00 per missed appointment. This charge is the patient’s responsibility and will not be billed to your insurance.

**Insurance Initials: \_\_\_\_\_\_\_\_\_**

Your insurance policy is a contract between you and your insurance company. You are responsible to ensure payment from your insurance carrier. SPORTS, LLC will bill your insurance and make every effort to ensure that claims are promptly and correctly processed.

* All co-payments and deductibles are due at the time of service.
* Referrals: If required by your insurance, it is your responsibility to bring the referral at the time of service. We cannot provide treatment beyond the initial visit if your forget to bring your prescription or referral. You will be held financially responsible for any treatment rendered without proper documentation or authorization.
* SPORTS, LLC does not accept litigation cases. Payment is due in full at the time of service.
* SPORTS, LLC will verify your insurance coverage. Please note that the information provided to SPORTS, LLC by your insurance carrier may not be entirely accurate as deductibles and copays can vary depending on different factors and plans of coverage. **It is the patient’s responsibility to be aware of their insurance coverage and pay all costs associated with treatment rendered by SPORTS, LLC.**

**Privacy Policy Initials: \_\_\_\_\_\_\_\_\_**

Your privacy is important to SPORTS, LLC. By initialing this form, you acknowledge that you received a copy of our Notice of Privacy Policy and consent to our use and disclosure of your protected information for the purpose of treatment, payment and healthcare services.

In addition to my physicians and insurance company, I authorize the release of my health information to the following person, organization and/or attorney listed below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Telephone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Telephone Number

**Signature of Patient or Responsible Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Privacy During Treatment Initials: \_\_\_\_\_\_\_\_\_**

In order to ensure complete privacy while communicating with your therapist during assessment and treatment, I understand that it is my responsibility to let my therapist know if I am uncomfortable with any particular evaluation, procedure or treatment. I expect that the therapist will explain in advance what will be done and why it is necessary.

**Direct Payment Initials: \_\_\_\_\_\_\_\_\_**

By initialing, you authorize and direct your insurance company to pay Sports and Orthopaedic Therapy Services, LLC directly for their portion of the allowed services.

**Billing Office Initials: \_\_\_\_\_\_\_\_\_**

All billing questions should be directed to our billing services at (301)946-7717. Normal business days are Monday, Thursday and Fridays.

I have read and understand all of the above policies.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Full Printed Name Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**

**Authorization to Leave Voicemails, Text Messages and Emails**

The HIPAA Privacy Rule permits health care providers to communication with patients regarding their health care. This includes communicating with patients at their homes, whether through mail, phone or in some other manner. In addition, HIPAA Privacy Rule does not prohibit covered entities from leaving messages for patients on their answering machines. However, to reasonably safeguard the individual’s privacy, covered entities should take care to limit the amount of information disclosed in the message.

A covered entity may also leave a message with a family member or other person who answers the phone when the patient is not home. The Privacy Rule permits covered entities to disclose limited information to family members, friends, or other persons regarding an individual’s care, even when the individual is not present; however, professional judgment should be exercised.

The HIPAA Privacy Rule also prohibits the practice from using or disclosing patient protected health information (PHI) outside the Notice of Privacy Practice without the authorization of the patient. Messages that contain patient PHI require the patient to sign an authorization form to receive messages by phone, fax, email, text message, voicemail or any other means by which someone other than the patient might reasonably have access to the message, thereby potentially violating the patient’s privacy rights under HIPAA. For example, messages that contain PHI would be test results, medication information, payment information, treatment plans, patient condition information, and anything else that is considered patient condition, treatment or payment related.

You may elect to have your PHI provided to you by message from SPORTS, LLC by signing this form in the space provided below. Once you have signed this form, future communication with you concerning your PHI may be provided to the designated relative or friend, sent by email, fax or left on your voicemail at the number you provide to SPORTS, LLC.

I understand my HIPAA rights and I request that this office leave messages, including those containing PHI, for me with either of the individuals listed above or by email or voice mail at the numbers provided to SPORTS, LLC. I understand that it is my responsibility to keep the practice informed of any changes in this information.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_