

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for **Genesis Sports Medicine and Rehabilitation** to furnish medical care and treatment to {physician's name (s)} _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party: _____ Date: _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to **Genesis Sports Medicine and Rehabilitation** for services provided by **Genesis Sports Medicine and Rehabilitation**. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party: _____ Date: _____

FINANCIAL POLICY STATEMENT

We verify your insurance benefits as a courtesy to you. However, **Genesis Sports Medicine and Rehabilitation** does not accept responsibility for any incorrect information given by your insurance carrier regarding your insurance benefits or benefit plans. We require that any co-pays that are due be paid at each visit. Once your insurance carrier processes your claim we will bill you for any remaining patient responsibility deemed by your insurance carrier. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to **Genesis Sports Medicine and Rehabilitation**.

The above may not apply for those patients that are considered Workers' Compensation, Medicare Primary or who have benefits with a balance billing contract, such as an HMO. However, be advised if you claim Workers' Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs, collection agency fees, and attorney fees.

NO / SHOW CANCELLATION POLICY

I understand and agree that I am responsible for my appointment date(s) and time(s). I also, understand that as a courtesy, I am allowed two (2) missed and no show appointments. I will be charged \$20.00 for any missed and no show appointments thereafter. I understand and agree to the terms of this policy.

Patient/Guardian Responsible Party: _____ Date: _____

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

PATIENT/GUARDIAN/RESPONSIBLE PARTY

DATE

FACILITY REPRESENTATIVE

DATE