SPORTS AND ORTHOPAEDIC THERAPY SERVICES, LLC

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 can not provide treatment beyond the initial visit if you 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.

Privacy Policy **Initials:** _____

(Health Information)

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 protected health information about you for treatment, payment and health care services.

☐ **"**I wish to have the following restrictions on the disclosure of my health information and treatment."

_____

_____ _____

(PATIENT SIGNATURE) (DATE)

☐ "I authorize the release of my health information to the following person, organization and/or attorney listed below:"

_____
(NAME AND TELEPHONE NUMBER)

_____
(NAME AND TELEPHONE NUMBER)

_____ _____
(PATIENT SIGNATURE) (DATE)

(Privacy during Treatment) **Initials:** _____
By initialing, you understand that due to the nature of the facility it may not be possible to fully ensure complete privacy during communication 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's 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 rendered by a check made out and mailed to:

Sports and Orthopaedic Therapy Services, LLC
10605 Concord Street, Suite 105
Kensington, MD. 20895

Billing Office
All billing questions should be directed to our business office at 301-893-1061. Normal business hours are M-F 9:00am to 4:00pm.

I have read and understand all of the above polices.

_____
(Full printed name)

_____ _____
(Signature) (Date)