



Policy Acknowledgement and Signature Page

Acknowledgement of the HIPAA Privacy Notice

By signing below I acknowledge that I was offered the opportunity to review the SportsPlus Sports Medicine and Physical Therapy Center's HIPAA Privacy Notice.

I would like to have a copy of this office's HIPAA Privacy Notice.

I would not like to have a copy of this office's HIPAA Privacy Notice.

I refuse to sign because

Print Patient Name:

Date:

Patient Signature:

Parent/Guardian Signature:

Acknowledgement of Cancellation and No-Show Policy

By signing below I acknowledge that I have read and understand the SportsPlus Sports Medicine and Physical Therapy Center's Cancellation and No-Show Policy.

Print Patient Name:

Date:

Patient Signature:

Parent/Guardian Signature:

Authorization to Provide Medical Treatment and Assignment of Insurance Benefits

Your signature is required to authorize medical treatment, the release of healthcare information needed to process your claim, and allowing assignment of benefits to SportsPlus Sports Medicine and Physical Therapy Center where a claim has been filed. You understand that you are financially responsible for all charges whether or not covered by insurance. You certify that all demographic information, insurance information, and health information is correct to the best of your knowledge and that you will notify SportsPlus Sports Medicine and Physical Therapy Center immediately if any of this information changes.

Patient Signature:

Date:

Policy Holder Signature (if different from patient):

Relationship to patient: