ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES **Initial_____**

Mountaintop Physical Therapy and Wellness Center may use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities and have copies available for distribution.

No Show/ Late cancellation **Initial_____**

I agree to accept MountainTop's policy of a $25-dollar no-show fee if I do not give appropriate notice that I need to miss or reschedule an appointment. Appropriate notice will be considered more than 6 hours prior to the appointment time but preferably the day before the appointment so that we have ample opportunity to try to fill that appointment slot.

CONSENT FOR CARE AND TREATMENT **Initial_____**

I, the undersigned, do hereby agree and give my consent for MountainTop Physical Therapy and Wellness Center to furnish medical care and treatment to (please print name) _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition. I understand that exercising in a PT clinic and fitness center environment has inherent risks and I agree to hold harmless and waive any injury claims against MountainTop Physical Therapy or its employees for injuries that may occur on these premises.

BENEFIT ASSIGMENT/RELEASE OF INFORMATION **Initial_____**

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payors to MountainTop Physical Therapy and Wellness Center. 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.

FINANCIAL POLICY STATEMENT **Initial_____**

We will bill your insurance carrier solely as a courtesy to you. You are responsible for any applicable copay when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 45 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. I understand and agree that I am responsible for all deductible, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to MountainTop Physical Therapy and Wellness Center.

The above does not apply for those patients that are on an HMO plan or considered Worker's Compensation (W/C). However, be advised if your W/C benefits are denied, you may be held responsible for the total amount of charges rendered to you.

MountainTop Physical Therapy and Wellness Center will charge you a $20 return check fee for checks returned unpaid by your bank.

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 of collecting monies owed, including court costs, collection agency fees and attorney fees.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____

Patient/Parent/Guardian/Responsible Party **Date**

_____

Printed Name