

ATHLETIX

REHAB  RECOVERY

PATIENT AGREEMENT FORM

Thank you for selecting Athletix Rehab and Recovery, LLC. In order to facilitate your treatment, we ask that you read and sign this agreement and authorization.

- A scheduled appointment must be cancelled or rescheduled within at least **24 hours of scheduled appoint, to avoid \$50.00 no-show fee.**
- You agree to be responsible for payment of all fees in full at the time of your appointment, including copayments.

COPAYMENT/COINSURANCE PROMISSARY AGREEMENT

Your insurance company requires a Copayment/ Coinsurance to be paid when you seek certain medical services. In turn, we are contractually obligated to collect any deductible, copayment, or coinsurance from our patients.

I acknowledge that my insurance company and I have an agreement and I am responsible for the payment of any copayment, coinsurance, or deductible for health services provided to me, or my dependent.

I promise and attest that I will pay the required deductible, copayment, or coinsurance to Athletix Rehab & Recovery within thirty (30) business days from receiving a bill. Patient statements are mailed when explanation of benefits are received from your insurance company.

I understand failure to make payment, or to arrange payment that satisfies our financial policies, in thirty (30) business days may result in and health insurance notification and **an additional \$30.00 administrative fee to be added to the original amount due.**

Signature of Patient

Date

CONSENT FOR MEDICAL TREATMENT

I hereby authorize and request Atheltix Rehab and Recovery, LLC to provide such medical care and administer procedures and treatments as in the judgment of the Florida State licensed physical therapist in attendance and deemed necessary and advisable. The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Signature of Patient

Date