SPINE & SPORT
PHYSICAL THERAPY

217 N. 2nd E
Rexburg, ID 83440
208.359.6127
fax 208.359.9479

Patient Name _____ **Patient Guardian**:_____

Patient Employer: _____

Patient/Responsible Party Employer: _____

Notice of Privacy Rights

I acknowledge that I have been presented with a copy of Spine & Sport Physical Therapy's Notice of Privacy Rights.

Consent for Assessment & Treatment

I request the clinical staff of Spine & Sport Physical Therapy to provide me with the necessary medical assessment & treatment.

Assignment & Release

I hereby authorize my insurance benefits to be paid directly to Spine & Sport Physical Therapy, and I am financially responsible for non-covered services. I also authorize Spine & Sport Physical Therapy to release any information required to process this claim.

Authorized Signature _____ Date _____

Medicare Patient Signature Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Spine & Sport Physical Therapy for any services furnished to me by Spine & Sport Physical Therapy. I give permission to the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Authorized Signature _____Date _____

Audio Recording Consent Form

I acknowledge and understand that the providers will be using PredictionHealth's AI scribing software service during our visits moving forward. This Software will record and process the audio of our conversation to auto-generate the Provider's documentation and administrative work to help ensure the highest quality of care possible. By signing this Audio Recording Consent Form, I expressly certify that I understand that:

A. The Provider will be using the Software to capture conversations between me and the Provider in order to auto-generate the Provider's documentation and administrative Work.
B. The audio will be processed by the Software and will record my protected health Information.
C. The audio recording will be used for clinical purposes only, including treatment, payment or health care operations in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). It will not be used for any other purposes, including, for example, sharing, selling or using the audio recording for advertising purposes not in accordance with HIPAA.
D. The audio recording will be stored securely as part of my medical record in accordance with the applicable security regulations of HIPAA.

I have read all of the information above, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. By signing below, I expressly consent to the use of the Software and to have the audio of my visits recorded to support my Provider's clinical work.

Patient Signature_____Date of Birth_____Date_____

If you are completing this form as a parent, legal guardian, or health care agent, please fill out the section below:
Name of Person Completing Form_____ Relationship to Patient_____
Signature of Person Completing Form_____ Date_____

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Financial Policy

We require that you pay your co-pays, deductibles, and other payments due at the time of service. You may need to come in for multiple visits until your therapy is complete. Therefore, at Spine & Sport Physical Therapy, we offer flexible payment options.

Credit Card Authorization and Payment Agreement

To streamline your care and simplify billing, Spine and Sport Physical Therapy requires a credit card on file for all patients. This form authorizes us to charge your card for any patient responsibility after your insurance company has processed your claims. If a balance remains after two statements and no payments have been made, the card on file will be charged.

I authorize Spine and Sport Physical Therapy to securely store my credit card information and charge my card for amounts not covered by my insurance, including but not limited to:

- Co-pays, Deductibles, Co-insurance, Denied or non-covered services

I understand:

- I will receive a statement or receipt for charges to my credit card.
- I am responsible for any portion of the bill not paid by insurance.
- This authorization is valid until I revoke it in writing.
- My card information is stored securely via a HIPAA-compliant payment system.
- I may request a detailed receipt of charges at any time.

Patient Name: _____ Date of Birth_____

Cardholder Name: _____

Cardholder Signature: _____Date_____

If the cardholder is not the patient, what is your relationship to the patient?

☐ *Parent/Guardian* ☐ *Spouse* ☐ *Other:* _____

Payment Agreement & Collections

I agree to pay my account in full at the time of services. I understand that Spine & Sport Physical Therapy will submit insurance benefits for payment only as a courtesy to me. I agree to pay all charges for services provided by Spine & Sport Physical Therapy that are not covered by my insurance. I understand that I am responsible for the full balance on my account, regardless of insurance payment status. If my account becomes delinquent and is referred to a collection agency, I agree to pay all reasonable costs associated with collection, including attorney's fees and other legal expenses incurred in the process of recovering payment.

I have read/understand, and agree to Spine & Sport Physical Therapy's *Payment Agreement & Collections Policy*.

Authorized Signature _____Date _____

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Late Cancellation & Missed Appointment Policy

At Spine & Sport Physical Therapy, we value your time and are committed to providing the highest level of care. To ensure that all patients have access to appointment availability, we ask that you notify us **24 hours in advance** if you need to cancel or reschedule your appointment.

Missed Appointment Fee:

If you **miss an appointment without notice** or **cancel/reschedule with less than 24 hours' notice**, you may be charged a **$20 no-show fee**. This fee **will not be billed to your insurance** and **will be charged directly to the credit card on file**.

We understand that emergencies and unforeseen circumstances can occur. If this happens, please contact our office as soon as possible, and we will do our best to accommodate you.

I have read/understand and agree to Spine & Sport Physical Therapy's *Late Cancellation and Missed Appointment Fee*

Authorized Signature _____Date _____