Patient Name: _____

Welcome to *Abilene Bone & Joint/ Action Sports Medicine & Physical Therapy*. We are pleased to have you as our patient. It is our goal to see that you receive the best care possible. The staff at *Abilene Bone & Joint/ Action Sports Medicine & Physical Therapy* look forward to caring for you.

Acknowledgment of notice of privacy practices

I have been provided with and understand the notice of privacy practices of *Abilene Bone & Joint/ Action Sports Medicine & Physical Therapy* which describes details of uses and disclosures of my protected health information. I understand that the Abilene bone and joint/ action sports medicine and physical therapy reserves the right to change their notice of private practices, and will have the revised notice available for my review upon my request.

Print: _____ Date: _____

Signature: _____ Date: _____
(Patient, Parent, or Legal Guardian)

Patient consent

Consent to evaluation and treatment

I do hereby consent to the evaluation and treatment by *Abilene Bone & Joint/ Action Sports Medicine & Physical Therapy*. I understand it is my right to accept or refuse and treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to other results that may be obtained from such treatment.

Signature: _____ Date: _____
(Patient, Parent, or Legal Guardian)

Payment agreement

Claims to your insurance company will be filed by *Abilene Bone & Joint/ Action Sports Medicine & Physical Therapy*, and the remaining balance (if any) will be your responsibility. **Co-pays will be collected every visit if a co-pay is required by your insurance plan.**

Please choose the option of payment for the office visit and/ or the physical therapy services you will receive:

_____ Option 1- Major Medical/ Health Insurance/ Tricare

_____ Option 2- Medicare or Medicaid

_____ Option 3- Workers' Compensation

_____ Option 4- School Insurance

_____ Option 5- Private Pay

_____ Option 6- Accident- other than Workers' Compensation

I authorize payment of medical benefits to *Abilene Bone & Joint/ Action Sports Medicine & Physical Therapy* for an insurance filed by the clinic. I also authorize the release of any necessary information to process any of the above insurance claims.

I agree to the following payment plan established between myself (or personal representative) and *Abilene Bone & Joint/ Action Sports Medicine & Physical Therapy*. If payment plans ever need revising, I will contact *Abilene Bone & Joint/ Action Sports Medicine & Physical Therapy* to make arrangements. I understand that I am financially responsible for all charges even if insurance is pending and agree that I may be billed, and will pay accordingly.

Signature: _____ Date: _____
(Patient, Parent, or Legal Guardian)