Notice of Privacy Practices

Acknowledgement of Receipt

By signing this form, you acknowledge that you have received a copy of the Notice of Privacy Practice of ProFormance Therapy. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change.

I acknowledge a receipt of the Notice of Privacy Practices of ProFormance Therapy.

X_____ Date_____

Patient/Guardian Signature

ProFormance assumes no liability for any benefits information that is misquoted by your insurance carrier. It is your ultimate responsibility to be aware of your insurance coverage, limitations, and terms and conditions of your policy. Benefits and verification are performed as a courtesy to you. ProFormance cannot be responsible for any information that is obtained directly from your insurance carrier that is later deemed inaccurate. You are responsible for payment of any deductible, copayment and coinsurance as determined by your policy. If additional treatment is necessary beyond your policy visit limits or dollars amount, we may consider alternative payment options. I understand ProFormance requires 24 hour notice of cancellation and that ProFormance reserves the right to charge a $50 fee for failing to cancel a scheduled appointment.

Consent To Treat & Authorization to Release information, Assignment of Benefits

I hereby authorize ProFormance, through its appropriate personnel, to perform the Functional Capacity Evaluation procedure, as well as take/ provide any photographs that are deemed necessary by my physician and therapist in the treatment of my condition. I further authorize ProFormance to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment. I am assigning my therapy benefits to ProFormance for the services in which I receive and authorize my insurance carrier to make payments to ProFormance on my behalf. All records releases require an administrative and copying fee paid to ProFormance before they are released, regardless of requestor. ProFormance is HIPPA compliant with regard to information sharing policies. I agree to contact ProFormance Therapy the day following my exam to inform them of my discomfort, pains, aches or lack thereof. A failure to contact ProFormance Therapy the next day confirms that no discomfort has been experienced as a result of the testing and indemnifies ProFormance Therapy of any possible future claims on injuries as a result of testing.

By signing this document, I acknowledge that I have read, understand and agree that the information contained in this document including insurance benefits and any information I have presented to verify my own identity including my state issued driver license, state issued photo identification card or my passport, and if applicable any information used to verify the identity of a minor beneficiary is current, correct and complete to the best of my knowledge. I agree to the financial terms stated above.

X_____ Date_____

Signature of Patient or Responsible Party