

IMPACT SPORTS MEDICINE (ISM)

Patient: _____ **Date:** _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION/ HIPPA

I, hereby assign all medical benefits to which I am entitled, including Medicare, private insurance, and third party payers to ISM. A photocopy of the assignment is to be considered as valid as the original. I, hereby authorize ISM to release all information necessary, including medical records, to secure payment. I acknowledge that I have read the HIPPA Notice of Privacy Practices.

Patient/Guardian: _____ Date: _____

INSURANCE BENEFITS AS PER PRE-AUTHORIZATION

As a courtesy to our patients, ISM contacts your insurance company to preauthorize your treatments. The below stated benefits were determined by your insurance company, however, insurance companies may alter their agreement to pay. It is the patient's responsibility to know their benefits, therefore we advise you to call and confirm your benefits. I acknowledge receipt of this information.

_____ Co-Pay _____ Deductible _____ Amount Met _____ Co-Insurance _____ # of Visits
Other: _____

Patient/Guardian: _____ Date: _____

FINANCIAL POLICY STATEMENT

As a courtesy to you we bill your insurance carrier. We require co-payments and self-payments to be made at the time service is rendered. If co-insurance/deductible is applied you will be billed after your insurance company notifies us of your patient responsibility on your EOB. If your insurance benefits are denied or not in effect, you will be held responsible for the total billed amount. If any payment is made directly to you for the services billed by ISM, you are obligated to promptly remit payment in full to ISM within 30 days.

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 incurred by collecting monies owed. These costs include but are not exclusive to court costs, collection agency fees, attorney fees and returned check fees. I have read the above information and understand my responsibility for the payment of my account.

Patient/Guardian: _____ Date: _____

I authorize IMPACT SPORTS MEDICINE to maintain my credit/debit card on file until my bill has been paid in full. I agree to pay the total amount due according to the above agreement. I understand that this form is valid for two years unless I cancel the authorization through written notice to IMPACT SPORTS MEDICINE and ISM agrees to termination. As a courtesy, IMPACT SPORTS MEDICINE will attempt to notify me of the balance being charged by calling the below stated phone number. The receipt will be mailed to you.

Card Holder Signature: _____ Date: _____

Phone Number: _____