IN CONSIDERATION OF TRETMENT BY THE DOCTOR, I THE UNDERSIGNED(S), JOINTLY AND SEVERALLY, UNDERTAND AND AGREE

1) That I am responsible for all fees relative to the professional services rendered under this agreement, that may include me, my family, or other individuals that I authorize, and that this agreement as it relates to my financial responsibility extends to all past, present, and future services rendered by the doctor and the staff to me, my family or other individuals I may have authorized. I recognize that insurance is a contract between the patient and insurance company, and I agree that I will pay all charges under this agreement by the pay my account in full and giving written notice to the doctor.
2) I agree to pay all attorney fees, including charges or commissions up to 50% that may be assessed to me by a collection agency retained to pursue this matter with or without suit.
3) I grant my permission to your office to contact me at home or place off business to discuss matters related to this form. I also agree to let this office, and any collection agency this practice decides to use. I authorize release of information to insurance carriers to collect on my behalf. I authorize payment to come directly to your office.
4) In the even that the patient's portion would impose a financial hardship, payment plan options can be discussed, and a written contract will be signed prior to treatment. Payment plans can be tailored to each individual patient; however, we are not a bank or creditor and cannot accept minimal payment.
5) This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.
6) ***Notice of Privacy Practices:*** I acknowledge that I have received a copy of this office's Notice of Privacy Practices which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, health care operations and other described and permitted uses and disclosures. I hereby agree to abide by the conditions outline herein.
7) ***Consent to Email for Appointment Reminders and other Healthcare or Clinic Communications***: Patients in our practice may be contacted via email/text messaging to remind you of an appointment, to obtain feedback on your experience, and to provide general health reminders/information regarding Ultimate Sports Performance and Rehabilitation.
    a. Email that I authorize: ____
    b. Cell Phone that I authorize: ____
8) Consent to treat a minor:
    a.____________ (Parent/Guardian Initials) I hereby give my consent to treat my minor child

____ _________________________

Signature of patient, parent, guardian Date