Pro-Activities, LLC — Patient Authorization

Patient Name:

Release of Information & Consent for Treatment

All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at Pro-Activities, LLC subsidiary or affiliate company. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Pro-Activities, LLC and its subsidiaries and/or affiliates to release information, verbal and written, contained in my medical record, and other related information to my insurance company, rehab nurse, care manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.

I authorize Pro-Activities, LLC, and its subsidiaries and/or affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understand the above information.

Assignment of Benefits

I authorize payment directly to Pro-Activities, LLC its subsidiaries and/or affiliates for services.

This is a direct assignment of my rights and benefits under this policy.

A photocopy of this assignment shall be considered as effective and valid as the original.

Notice of Privacy Practices (HIPPA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Pro-Activities, LLC and its subsidiaries and/or affiliates.

In addition, I hereby consent to the use and disclosure of my personal health information for the purpose of treatment, payment, and health care operations.

Payment Guarantee

I agree to pay Pro-Activities, LLC, its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment and services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Pro-Activities, LLC its subsidiaries and/or affiliates.

Patient or Guardian Signature: **Date:**