

<b>SOCIAL SECURITY #</b>	<b>HEALTH INSURANCE I.D. #</b>
<b>PATIENT NAME</b>	
<b>ADDRESS</b>	<b>TELEPHONE NUMBER</b>
<b>TYPE OF EQUIPMENT</b>	
<b>Effective date:</b>	

**REQUEST FOR PROVISION OF SERVICES**

The undersigned, being the above-named patient (the "Patient") or guardian or representative payee of the Patient, understands that signing this Patient Agreement and Consent indicates his/her desire to purchase health care products or services or both from SportWorks Rehabilitation Center or its affiliates.

**ACKNOWLEDGMENT OF MEDICAL RESPONSIBILITY**

The undersigned, as or on behalf of the Patient, understands that (A) Patient is under the supervision and control of his/her attending physician; (B) Patient's physician has prescribed the therapy noted as part of Patient's treatment; (C) SportWorks Rehabilitation Center services do not include diagnostic, prescriptive or other functions typically performed by licensed physicians and (D) Patient's physician is solely responsible for diagnosing and prescribing drugs and therapy for Patient's condition and otherwise supervising and controlling Patient's medical condition.

**AGREEMENT TO PAY**

In consideration of SportWorks Rehabilitation Center undertaking to supply Patient with any products and/or services ordered by or on behalf of Patient, the undersigned agrees that he/she is responsible for payment to SportWorks Rehabilitation Center for all such products and/or services provided to Patient. In addition, the undersigned understands that the monthly balance due will be the portion of applicable charges that is unpaid by Patient's insurance, including copayment and deductible amounts. The undersigned agrees to pay the balance due in full upon receipt of and invoice therefore from SportWorks Rehabilitation Center. If payment is not made, the undersigned understands that SportWorks Rehabilitation Center will pursue its normal collection policy with respect thereto.

**RELEASE OF INFORMATION**

Patient's insurer(s) and any other third party payor(s) which provide Patient with coverage are hereby authorized by or on behalf of Patient to disclose to SportWorks Rehabilitation Center any information regarding such coverage, including but not limited to (A) payment made by such insurer(s) or third party payor(s) to Patient or the undersigned for products and/or services rendered to Patient by SportWorks Rehabilitation Center and (B) the scope and extent of coverage from time to time. All medical personnel are hereby authorized by or on behalf of Patient to disclose information to SportWorks Rehabilitation Center concerning Patient's medical history as it may relate to the therapy rendered to Patient by SportWorks Rehabilitation Center. In signing this Patient Agreement and Consent, the undersigned, as or on behalf of Patient, authorizes any holder of medical or other information about Patient to release to the Social Security Administration, its intermediaries or carriers, or to any third party payor(s), including without limitation Medicare, Medicaid, OCHAMPUS or private payors and their agents any information needed to determine applicable benefits and process claims for these or related services.

**CREDIT CHECK AUTHORIZATION**

SportWorks Rehabilitation Center is hereby authorized to verify any information disclosed by Patient or the undersigned and to perform a credit investigation for the purposes of extending credit for the purchase or rental of medical equipment. In addition, SportWorks Rehabilitation Center is authorized to answer any questions from other creditors about Patient's credit and account experience with SportWorks Rehabilitation Center.

**ASSIGNMENT OF BENEFITS**

The undersigned, as or on behalf of Patient, hereby authorized SportWorks Rehabilitation Center to request on Patient's behalf, and to collect directly, all public and private insurance coverage benefits due for products and/or services supplied to Patient by SportWorks Rehabilitation Center. In the event payments for insurance benefits are made directly to Patient or the undersigned, the payee will endorse to SportWorks Rehabilitation Center all checks for such payments. Responsibilities for overpayments accepted per statement.

**EXTENDED ASSIGNMENT OF MEDICARE AND OTHER BENEFITS**

The undersigned certifies that the information provided to SportWorks Rehabilitation Center by or on behalf of Patient for payment under Medicare (title XVIII of the Social Security Act) and/or any other medical insurance is correct.

1. Patient, if physically and mentally competent, must sign on his/her own behalf. If Patient cannot sign for himself/herself, a representative payee as designated by the Social Security Administration or a legally appointed guardian may sign on behalf of Patient. The source of the signatory's authority must be stated.
2. This Patient Agreement and Consent is used in lieu of the Patient's or his/her representative's signature on the "Request for Payment" HCFA-1500 (184) and is therefore an extension of that form. Anyone who misrepresents or falsifies essential information in making a Medicare claim may, upon conviction, be subjected to a fine and imprisonment under Federal Law. Penalties may also result from falsification or misrepresentation of other medical insurance claims. The undersigned, as or on behalf of Patient agrees that a copy of this Patient Agreement and Consent may be used in place of the original.
3. On assigned Medicare claims, SportWorks Rehabilitation Center agrees to accept the applicable Medicare carrier's allowable amount as payment in full for services. The undersigned is responsible for the payment of deductibles, copayments and co-insurance and for non-covered services. The agreements contained in this paragraph may be canceled by mutual agreement of SportWorks Rehabilitation Center and the undersigned, as or on behalf of Patient, at any time by written notice to the applicable Medicare carrier.

The undersigned certifies that he/she has read the foregoing and received a copy of this Patient Agreement and Consent, including a copy of the Patient Responsibilities on the reverse side hereof, as well as a copy of the Patient Bill of Rights. The undersigned further certifies that he/she is the Patient or duly authorized to execute this Patient Agreement and Consent and accepts its terms on behalf of Patient.

**A copy of this Patient Agreement and Consent shall be considered the same as original.**

PATIENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_ DATE \_\_\_\_\_

WITNESS \_\_\_\_\_ DATE \_\_\_\_\_