Advanced Motion
PHYSICAL THERAPY

RELEASE OF INFORMATION

In order to protect the privacy of your medical and financial information we request that you complete the form below to help us better serve you. We have provided a HIPAA (Health Insurance Portability and Accountability Act) pamphlet to help explain this in more detail.

I authorize the staff of Advanced Motion Physical Therapy Inc. to release any medical/ financial information to the following people and or businesses.

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Please Initial----→ ☐

MODEL RELEASE FOR PHOTOGRAPHY

I hereby give permission to Advanced Motion Physical Therapy to use my photo and likeness in all forms and media for medical reports, updates, editorial altering without restrictions and other lawful purposes. I understand I am entitled to no compensation. I release the photographer all forms of claims and liability related to my photo and or video usage.

Please Initial----→ ☐

FINANCIAL AGREEMENT

A. I, the undersigned give permission to release information to third party carriers and do assign all insurance benefits for treatment to be paid directly to the above named provider and request that this assignment remain on file with any insurance carrier. I certify that a copy of this assignment shall be as valid as the original.

B. I agree that I am responsible for this debt regardless of insurance or other reasons and that I will pay any unpaid balance in full within **90 days of the date of service**. I agree to pay 18% interest per annum on the unpaid balance compounded daily.

C. In the event that my account is not paid as agreed or is delinquent, I agree to pay a **collection agency fee of 50%** of my unpaid balance in addition to my balance and any accrued interest charges if turned over to a collection agency.

D. In addition to a collection agency fee of 50%, I also agree to pay a reasonable attorney's fee at the rate of $150 per hour. In the event that it becomes necessary for the collection agency of the original creditor to bring legal suit to collect this debt, I also agree to pay the costs of the court and submit to the jurisdiction of the Third District Court SL County State of Utah.

E. If any portion of this bill or the provided services is disputed, I agree to submit myself and the dispute to alternative resolution (mediation and arbitration) and agree to bear the cost of doing so.

F. I accept to a therapy evaluation and subsequent treatment provided and directly supervised by a licensed physical or occupational therapist employed by Advanced Motion Physical Therapy Inc.

G. In the event that industrial or auto insurance exhausts or refuses to pay, I authorize Advanced Motion to bill my health insurance.

Please Initial----→ ☐

"NO-SHOW" POLICY

I UNDERSTAND THAT A **$20 FEE** WILL BE ASSESSED IF I DO NOT SHOW UP AN APPOINTMENT WITHOUT CANCELING. I UNDERSTAND THAT THIS FEE WILL NOT BE COVERED BY MY INSURANCE.

Please Initial----→ ☐

Patient Signature ________________ Date ________________

Parent or Guardian Signature if patient is under 18 ________________ Date ________________