



Consent for Care and Treatment

I _____, the undersigned, do hereby agree and give my consent for Centennial Sports & Physical Therapy (CSPT) to furnish medical and treatment considered necessary and proper in diagnosing or treating my physical and medical condition.

Scheduling Appointments/Attendance

Centennial Sports and Physical Therapy is dedicated to delivering high-quality care to all our patients. Patients are expected to keep their appointment times; no-show appointments result in unused physical therapy time that could be allocated to another patient. It is the patient's obligation to call and notify Centennial Sports and Physical Therapy when an appointment cannot be kept.

- Notification of a cancellation must occur **at least 24 hours before** your appointment, unless it is an emergency, or it will be documented as a NO SHOW. (A cancellation without notification)
- Arriving 10 minutes after your scheduled start time may also be considered a NO SHOW, and you may be asked to reschedule your appointment.
- **2 or more No Shows/Same Day Cancellations** may result in the patient being discharged from our practice.

Benefit Assignment/Release of Information

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third-party payers to Centennial Sports and Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, and payment to be sent directly to CSPT as outlined by my insurance policy.

Financial Policy Statement

COPAYMENTS ARE DUE AT THE TIME OF EACH TREATMENT. We will bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill when the services are rendered. We do check benefits and advise you of those quoted benefits; however, it is your responsibility to check your own OUTPATIENT PHYSICAL THERAPY BENEFITS. Follow up with your insurance company if you have any questions regarding the way they have or have not processed your claims.

I acknowledge that I have read and understand the policies as outlined above:

Patient/Guardian/Responsible Party: _____

Date: _____



Notice of Privacy Practices

Centennial Sports and Physical Therapy assures that patients are treated according to their rights defined by **HIPAA** (Health Insurance Portability and Accountability Act of 1996).

1. **Complaints**: If you desire further information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we have made about access to Protected Health Information, you may contact Sean Freeman at 509-928-6220. You may also file a written complaint with the Director, Office of Civil Rights, and the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with us or with the Office of the Director.
2. **Right to Request Additional Restrictions**: You may request restrictions on our use and disclosure of Protected Health Information (1) for treatment, payment and health care operations, (2) to individuals (such as family member, other relative, close personal friend, or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction.
3. **Right to Receive Confidential Communications**: You may request, and we will accommodate any reasonable written request, for you to receive protected health information by alternative means of communication or alternative locations.
4. **Right to Inspect and copy your Health Information**: You may request access to your medical file, as well as your enrollment, payment, and claims adjudication, case, and medical management records, and your billing records maintained by us.
5. **Right to Amend your records**: You have the right to request that we amend Protected Health Information maintained in your medical record file, enrollment, payment, claims adjudication, case, and medical management records, or billing records. We will comply with your request unless we believe that the information that would be amended is accurate and complete, or other special circumstances apply.
6. **Right to Receive a Paper Copy of this notice**: Upon request, you may obtain a paper copy of this notice, even if you agreed to receive such notice electronically.

Patient or Legal Guardian Signature

Date