PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND OFFICE POLICY

With my consent, Leading Edge, Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Leading Edge, Inc.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Leading Edge, Inc. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Leading Edge, Inc.'s Privacy Officer at 4406 S. Florida Ave., #16, Lakeland, FL 33813-2182.

With my consent, Leading Edge, Inc. may call, send mail, or may email my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, company specials & newsletters, and any call pertaining to my clinical care.

By signing this form, I am consenting to Leading Edge, Inc.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Leading Edge, Inc. may decline to provide treatment to me.

Custom Rehabilitation Program

Please bring to your Therapy appointments – loose fitting or sleeveless T-shirt, a pair of loose shorts and tennis shoes!

Your therapist will design *a **Custom Rehabilitation Program** just for you*. This program is designed for you to use in addition to your therapy at the clinic. You may do your custom rehabilitation program at the clinic and/or at home to speed your recovery. Your therapist will work with you so that you understand, and are comfortable with, your program and will answer any questions you may have.

You may have some temporary soreness or increased pain after your first few treatments. This is quite normal and usually improves fairly quickly as your therapy progresses. It's very important to let your therapist know exactly how you are feeling so your treatment can be adjusted as needed. *The days you hurt the most are usually when you need your therapy the most! So please come on in and let's get you feeling better!*

If you ever have any concerns about your treatment and/or program, please, address this with your therapist. Your communication will only help us do a better job for you.

Your child's safety is important to us. Due to the nature of our clientele and size of our lobby, we prefer that you find appropriate childcare. If you do have to bring your child and they are disruptive you may be asked to reschedule your appointment for another time. No children under 12 may be left alone in the lobby. Thanks for your understanding.

RETURNED CHECKS

There is a service charge of $35 for any returned check.

CASH PATIENTS

Payment is due at time of service, unless prior arrangements have been made.

COLLECTIONS

If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 30% of your outstanding balance.

INSURANCE

If you have insurance, and are covered for treatment, we will file all claims for you. Our office accepts assignment of benefits from your insurance provider. If there is a dispute with the insurance company regarding payment, "usual and customary" charges, deductibles, covered charges, etc., you will be responsible for the portion your insurance company will not pay. You are responsible for any percentage or co-pay amount per your insurance policy, not payable by the insurance carrier at the time treatment is rendered. The cash portion of charges for your visit is due at each visit. This amount is an approximation. We will gladly bill your insurance company for the remaining amount. After we hear from your insurance company concerning those charges, there may be an additional amount for which you are responsible. I further acknowledge that any benefits paid directly to the beneficiary for services provided by Leading Edge, Inc. will be endorsed and mailed to Leading Edge, Inc. within 10 days.

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask if you have any question about our fees, Office Policy, or your responsibility.

*We accept cash, checks, Visa, MasterCard, Discover, and American Express.

Your Co-Pay or percentage due each therapy visit is: $_____
(Please keep in mind, this is an estimate; it is possible that there could be an additional balance owed once insurance is filed)

Please allow us to make a photocopy of your id and insurance card.

I have received a copy of the NOTICE OF PRIVACY PRACTICES of Leading Edge Physical Therapy & Sports, Inc.

I have read Leading Edge's office policy. I understand this information, and have received a copy of it.

_____ _____

Signature Date