PLEASE SHOW YOUR MEDCIAL INSURANCE CARDS TO THE RECEPTIONIST.

CONSENT TO TREATMENT

For and in consideration of the medical treatment, which I may receive while a patient of ***Accelerated Rehab and Sports Medicine***, I either severally or collectively consent to treatment, voluntarily and knowingly, by me if of age and competent of for me, if a minor or incompetent, by my parents, guardian or nearest relative, as the case may be, to the said members of ***Accelerated Rehab and Sports Medicine***. Severally or collectively, to carry out, or cause to be carried out such medical treatment, as prescribed or ordered by my physician.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize ***Accelerated Rehab and Sports Medicine*** or any holder of medical information about me to release to the Health Care Financing Administration and its agents (Medicare) or Insurance Companies or Third Parties, any information needed to determine these benefits or the benefits payable to related services. I request that authorized Medicare or Insurance payments of medical benefits be made to ***Accelerated Rehab and Sports Medicine*** or to any consulting physician or entity used in connection with this service (to be used only if necessary to file claims).

GUARANTOR RESPONSIBILITY

In consideration of the services, I agree that I am solitarily liable for and hereby guarantee the payment of all facility charges incurred for my treatment in accordance with the orders of my prescribing or consulting physician(s), including any facility charge not paid, for any reason, by any payer or insurance company. I further agree that payment is due in full within 45 days of my discharge and that an interest rate of 11% per annum may be assessed against the balance remaining after payment is due as well as attorney fees of 25% of the principal interest due if the account is referred to an attorney for collection. If a balance cannot be paid in full after 45 days of my discharge, I agree to a payment schedule of $100 per month if my balance is $1 to $499, or $200 per month if my balance is $500 to $999, of $300 per month if my balance is greater than $1,000.

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by Accelerated Rehab and Sports Medicine and if this assignment is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel or court.

This authorization and assignment may be revoked by me at any time by a written notice, I agree that a photocopy of this form may be used in lieu or the original.

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Signature of Insured/Patient Date