THE TRAINING ROOM, LLC

POLICES AND NOTICES

_____**CONSENT FOR TREATMENT**: I hereby consent to the Evaluation and Management services provided by Stephen Hopkins, DPT. I understand that my consent may be revoked, in writing, at any time. However, such revocation does not release any financial obligation for services already rendered.

_____ **RELEASE/OBTAIN INFORMATION**: By signing below I authorize The Training Room, LLC to release to any insurance carrier represented as contractually responsible for payment in whole or in part of the my, or my dependent's, health care bill, such information as is deemed minimally necessary for the proper and accurate processing of such healthcare claims. Further, I understand that The Training Room, LLC may provide to outside healthcare providers/services such information as is deemed minimally necessary to facilitate proper healthcare.

_____ **STATEMENT OF FINANCIAL RESPONSIBILITY**: In consideration of medical treatment and service provided to the abovenamed patient, the patient or the undersigned Guarantor, unconditionally guarantees payment in full to Stephen Hopkins, DPT and The Training Room, LLC. The Training Room, LLC agrees to abide by the terms and conditions set forth in individual managed care contracts with which the patient and physician both participate. The Training Room, LLC will submit Claims for processing for Patients covered by insurance that do not have a managed care. However, the patient/guarantor is ultimately responsible for payment of the entire account balance regardless of insurance coverage or insurance benefit determination. Should an insurance carrier not pay on a claim within the mandatory 45-day State limit, the balance due will be the responsibility of the patient/guarantor. All co-pays are due at the time of service. The patient/guarantor understands he/she is responsible for providing accurate and complete information.

_____ **ASSIGNMENT OF INSURANCE BENEFITS:** The undersigned hereby authorizes any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's healthcare bill, including Personal Injury Protection or Medical Payment coverage, to pay directly to Stephen Hopkins, DPT and The Training Room, LLC proceeds and benefits payable to me. Additionally, I agree that any payments shall be applied toward any settlement or judgment I receive under any auto liability or uninsured/underinsured motorists coverage provided by Medical Payments coverage.

_____ **NOTICE OF PRIVACY PRACTICES:** I understand that as part of performing healthcare services, The Training Room, LLC creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment. I have been provided with a Notice of Privacy Practices (NPP) that provides a more complete description of the uses and disclosures of certain health information. I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures may have already been made based on my prior consent. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purpose of treatment, payment or health care operations, be restricted. I also understand that The Training Room, LLC and I must: agree to any restriction in writing on the use and

disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

I acknowledge and accept the terms and conditions set forth in Sections I, II, III, IV, V, and VI of this policy statement:

Signed: _____ Date: _____

Relationship to Patient: _____