445 St. Paul Street
Tel: (401)-597-5665 North Smithfield, RI 02896 Fax: (401)-597-5667

Patient Authorization

1. I authorize use of this form on ALL of my insurance submissions.

2. I request that payments of authorized benefits be made on my behalf to Matrix Sports Medicine & Physical Therapy, Inc. for any services provided to me by Matrix.

3. I understand that my signature authorizes that payment be made and that my medical information be released in order to pay the medical claim.

4. I understand that I am responsible for ANY DEDUCTIBLE, CO-PAYMENTS, CO-INSURANCE, and NON-COVERED SERVICES.

5. I understand that I am responsible for any UNPAID BALANCE ON MY ACCOUNT.

6. If suit is brought to collect on any outstanding balance due and owing with regard to the services rendered by Matrix, then in that event Matrix shall be entitled to collect all reasonable costs and expenses of collection and suit, including but not limited to reasonable attorney's fees.

7. I permit a copy of this authorization to be used in the place of the original.

8. **I understand that I (not the insurance company) will be charged a fee of $35.00 for any appointments cancelled without 24 hours notification. No Show also applies.**

_____ _____

Patient/Guardian Signature Date

Patient Consent

The physical therapist has discussed the proposed treatment, the material risks, expected benefits, and reasonable alternatives of the proposed treatments. My questions have been answered to my satisfaction and I hereby consent to the proposed treatment.

_____ _____

Patient/Guardian Signature Date