Cyd Charisse Williams, M.D, Dr. Katrina Thompson-Bowdry,
Mara Gardner, MHS/PT, LMT, NCTMB

Athletics
SPORTS MEDICINE, LLC

PATIENT INFORMATION

NAME:_____DOB:_____SS#_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____CELL PHONE:_____EMAIL:_____

REFERRED BY:_____REASON FOR APPT:_____

PRIMARY CARE PHYSICIAN:_____PHONE#_____

EMPLOYER:_____WORK PHONE:_____

EMERGENCY CONTACT:_____PHONE:_____

RESPONSIBLE PARTY INFORMATION

PARENT OR GUARDIAN:_____DOB:_____

ADDRESS:_____SS#_____

HOME PHONE:_____CELL PHONE:_____EMAIL:_____

INSURANCE:_____ID#_____GROUP#_____

PRIMARY INSURED NAME:_____DOB:_____SS#_____

Assignment of Insurance Benefits

I hereby assign directly to Athletics Sports Medicine payment of the insurance benefits otherwise payable to me, including Medicare benefits for any services furnished by Athletics Sports Medicine to me or my insurance carrier for services rendered by Athletics Sports Medicine at my earliest possible convenience along with any Explanation of Benefits regarding those payments, if applicable.

Authoriation to Release Medical Information

I authorize Athletics Sports Medicine to release any imforation such as medicial history and record of treament necessary to process a claim with my insurance carrier or its agents, including Medicare. This authorization extends to the Missouri Patient Care Review Foundation and those agents selected by my insurance carrier who are responsible for reviewing the appropriateness and quality of care

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furnished by Athletics Sports Medicine. The authorization also applies to physician services and other health care institutions including, but not limited to, other hospitals, home care agencies and long term care facilities whose services I may require upon discharge from treatment. I also understand that this facility will protect information here as a part of my care with Athletics Sports Medicine and furthur, will obtain written consent from me prior to such non-routine use or disclosure of my medical information.

Consent for Treatment

I am voluntarily seeking services from Athletics Sports Medicine knowing that I am suffering from a condition requiring medical care. I hereby voluntarily consent to such evaluation procedures and treatment as may be deemed necessary to me or in my capacity as guardian for the minor. I am aware that the practice result of evaluation and treatments.

Guarantee of Payment

I understand as a courtesy, Athletics Sports Medicine may contact my insurance carrier to verify my coverage for services. I understand that this DOES NOT guarantee coverage or payment on my account. As an additional courtesy, Athletics Sports Medicine may submit claims for services rendered to my insurance carrier, if applicable. I understand that consideration for payment is NOT a guarantee of payment. I agree to pay any applicable copays at the time o fmy visit and will be applied toward my account balance. I understand that this payment does not constiture full payment for my office visit and any treatent I may receive. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY FEES OCURRED DURING THE COURSE OF TREATMENT REGARDLESS OF MY INSURANCE COVER AND/OR LIMITATIONS. I agree to pay for any additinoal fees that may be incurred in an effort to collect this account including collection and/or legal fees. I agree to pay 1.5% per month (18% annualized) for any balance on my account. I also understand and agree that it is my responsibility to meet the requirement for referral, second opinion or pre-certification of my care as outlined by my insurance carrier and if these requirements have not been followed, I understand that I will be responsible for all charges incurred. In consideration of services to the rendered by Athletics Sports Medicine over and above the amount covered by insurance, the amount due for such services shall be standard charges made by Athletics Sports Medicine.

Athletics Sports Medicine and the patient or patient's representative hereby enters into the above agreement. The patient or patient's representative certifies that he/she has read and accepted the above, where applicable to the patient's condition and status and further certifies that he/she is the patient or is he/she duty authorized on behalf of the patient to execute such an agreement.

Patient Date

Responsible Party Date

Witness Date