MEDICAL AND SURGICAL CONSENT FOR TREATMENT

The patient is under the care of his or her attending physician(s) and herby consents to and authorizes Tower Aquatic & Sports Physical Therapy ("TASPT") to furnish the necessary treatments, supplies to the patient as ordered or requested by the attending physician(s) or responsible part. I acknowledge that no guarantee or assurance has been made as to the results of treatment, or examinations at TASPT.

RELEASE FROM LIABILITY FOR VALUABLES

I have been made aware that TASPT does not provides facilities for the safekeeping of valuables and I therefore release TASPT from any liability due to loss or damage to any valuables.

ITEMIZED STATEMENT

You have the right to receive an itemized bill upon request. You may request an itemized bill by sending a written request to TASPT, Attn: Office Manager, 209 Citrus Tower Blvd, Suite 108, Clermont, FL 34711 or by calling 352-242-9022.

NOTICE OF PRIVACY PRACTICES

By signature below, I acknowledge that I have received today, or during a prior admission, a copy of the TASPT Notice of Privacy Practices (NPP).

ASSIGNMENT OF INSURANCE BENEFITS

A. In the event I am entitled to benefits or other recovery of any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient(including but not limited to private and group health and hospitalization benefits, automobile liability, general liability, personal injury protection, medical payments, and uninsured or underinsured motor vehicle benefits) such benefits or recovery are hereby assigned directly to Tower Aquatic & Sports Physical Therapy (TASPT) for application to the patient's bill, and I authorize direct payment to TASPT of such benefits or recovery. It is agreed that TASPT may receipt for any such payment. I am responsible for charges not covered by this assignment.

B. I hereby assign the insurance benefits otherwise payable to the undersigned and/or patient to any involved provider(s) and I authorize direct payment to said providers of such benefits. I am responsible for charges not covered by this assignment.

C. Section 817.234, Florida Statutes, stipulates that "any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree."

ASSIGNMENT OF MEDICARE BENEFITS: PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST (Medicare Patients Only)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on the patient's behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for any applicable deductible and co-insurance, and non-covered charges, including personal charges.

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, I hereby consent to TASPT, its business associates, and any other healthcare provider involved in the patient's care using and disclosing all or any part of the patient's record for treatment and normal health care operations purposes. By signing below, I also hereby consent to TASPT, its business associates, and any other provider involved in the patient's care using and disclosing all or any part of the patient's record for the purpose of securing payment for services rendered by TASPT and/or other healthcare providers. Unless otherwise indicated, the information to be released includes all information in the patient's record including (if applicable) information about HIV testing and test results, psychiatric treatment, and treatment for alcohol or drug abuse, unless specific instructions are given below to withhold particular information. The foregoing restriction(s), if any, do not restrict the use and disclosure of the patient's record for treatment and normal healthcare operations. I understand that if I do not consent to release of information for payment purposes, TASPTal and other health care providers will be unable to bill my insurance company or other party which is or may be responsible for payment for the services documented by the withheld information and I will be billed directly for these services. This consent will remain in effect until revoked, except to the extent that action has already been taken in reliance upon it. Patients with implantable devices consent to the release of their Social Security numbers to the device manufacturer to comply with the Safe Medical Devices Act. For a more detailed description of uses and disclosures for treatment, payment or healthcare operations, please review the TASPT Notice of Privacy Practices (NPP),that is incorporated by reference. You have the right to review our NPP prior to signing this consent.

**** Please note that this is a read only document. Signing the consent form will be done at Tower Aquatics and Sports Physical Therapy on the day of your evaluation.****

Thank You.