5307 Yellowstone Rd
Cheyenne, WY 82009

Phone: 307-632-7677
Fax: 307-778-8292

(All patients must read and sign form prior to receiving services)

Thank you for choosing SMART Sports Medicine Center as your healthcare provider. We are dedicated to providing the best possible healthcare and rehabilitation to you, our patient. As a part of our professional relationship, it is important that you understand our consent, financial and HIPAA agreement.

I. CONSENT FOR MEDICAL TREATMENT

I authorize and consent to medical treatment.

II. FINANCIAL AGREEMENT

By accepting the services provided to me, I agree to be financially responsible for *all charges* for treatment.

SMART Sports will file my insurance as a courtesy to me and I am required to provide complete and accurate information.

I understand at the time of service I will be responsible to pay all co-pays and non-covered services, equipment or items not covered by my insurance company. I am responsible for any unpaid insurance balances. I will also be responsible for any attorney fees or collections related charges.

I do herby authorize my insurance carrier to pay directly to SMART Sports the insurance benefits otherwise payable to me for services rendered.

For Motor Vehicle Accidents: in case of a motor vehicle accident, we only bill your motor vehicle insurance. We do not bill third party claims and we do not accept liens. If you have a third party liability claim you will be required to pay at the time of each visit.

III. RELEASE OF MEDICAL INFORMATION

I authorize SMART Sports Medicine Center to release any medical information necessary to process my insurance claims. I do herby authorize SMART Sports Medicine Center, its successors and assigns to contact me with any information provided, including but not limited to: cell phone, email, emergency contact and my home address.

IV. MISSED OR CANCELLED APPOINTMENTS

In order to accommodate other patients who may be waiting for treatment, we require 24 hours notice if your appointment must be cancelled. We reserve the right to charge a **$35.00** fee for appointments that are not kept or cancelled within 24 hours.

V. HIPAA PRIVACY PRACTICE NOTICE

I acknowledge that there is a copy of the Notice of Private Practice displayed in the office of Vincent J. Ross, M.D. and on SMART Sport's website www.ssmcwy.com. I also acknowledge that I will be given a copy if requested.

I have read and understand the above.

Signature: _____ Date: _____