The information provided on this sheet is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to Mondo Sports Therapy. I also authorize Mondo Sports Therapy to release any information required to process my insurance claims.

**PT Benefits Provided by Your Insurance Company**

I understand that I am ultimately responsible for any copays, deductibles and/or co-insurance. I understand that the information provided regarding my insurance is an estimate and a quote of benefits and may not reflect the exact balance owed. I understand and agree that I will be financially responsible for any cost, share or balance due that Mondo Sports Therapy is unable to collect from my insurance and that I have the right and responsibility to follow up with my insurance for specific questions regarding my individual policy.

**No show/ Late Cancellation**

I am aware of the no show/ late cancellation policy and understand and agree that a fee of $50 will be charged to my account or $120/ $95 if my appointment is scheduled on a Saturday, should I be unable to comply with this policy. I further understand that this fee is not covered by my insurance carrier.

**Privacy Notice**

I acknowledge that I have read and fully understand Mondo Sports Therapy Policies. By signing this form, I am acknowledging my understanding of the "Notice of Privacy Practices" and I have been provided an opportunity to review it and understand my rights as stated therein.

**Release of Information**

I authorize the following individuals to receive information regarding my diagnosis, treatment, and billing:

| Name: | Relationship: |
|---|---|
| | |
| | |

Patient Name (please print) _____ Date of Birth _____

Patient or Guardian Signature _____ Date _____