Notice of Privacy Practices

Acknowledgement of Receipt

By signing this form, you acknowledge that you have been offered to ask about Endurance Rehabilitation & Athletics (hereinafter "ERA") Notice of Privacy Practices, which provides information about how we may use and disclose your protected health information.

_____ _____

Patient Signature Date

Consent To Treat & Authorization To Release Information, Assignment of Benefits

I hereby authorize ERA, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition.

I further authorize ERA to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment. I am assigning my therapy benefits to ERA for the services in which I receive and authorize my insurance carrier to make payments to ERA on my behalf. ERA reserves the right to seek reimbursement from any and all of your insurers regardless of whether you provide us with their contact information, unless you instruct us to bill you directly. All records released require an administrative and copying fee paid to ERA before they are released, regardless of requester. ERA is HIPAA compliant with regard to information sharing policies.

By signing this document, I acknowledge that I have read, understand and agree that the information contained in this document including insurance benefits and any information I have presented to verify my own identity including my state issued driver's license, state issued photo identification card or my passport, and if applicable any information used to verify the identity of a minor beneficiary is current, correct, and complete to the best of my knowledge. I agree to the financial terms stated above.

I further understand and acknowledge that ERA may lease/own or license real estate, equipment or other personal property (collectively "Property") from third parties to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. In consideration of being permitted to make use of and/or have access to the Property, I do hereby, on behalf of myself, on behalf of any minor or other person for whom I have requested such evaluation and treatment procedures ("Minor"), on behalf of my heirs, successors and assigns, and on behalf of such Minor's heirs, successors and assigns release and forever discharge any and all direct or beneficial owners of the Property and their respective successors, related entities, directors, officers, employees, and agents (collectively, "Releasees") from, and hereby waive and release, any and all claims, demands, actions, and causes of action whatsoever arising out of or in any way related to any loss, damage, or injury, including death, that may be sustained by me and/or such Minor in, on, in connection with or while making use of the Property, regardless of whether any such loss, damage, or injury is caused by the active or passive negligence of the Releasees or otherwise and regardless of whether any such liability arises in tort, contract, strict liability or otherwise, to the fullest extent allowed by law.

_____ _____

Patient Signature Date