1 Anderson Rd, Suite 104 Bernardsville, N.J 07924

Phone: 908-696-8900 Fax: 908-696-8902

1. ADMISSION CONSENT: I request and authorize Optimal Physical Therapy & Performance Institute to provide such outpatient care and to administer therapeutic procedures and treatment as in the judgment of the referring physician (s) they deem necessary or advisable in my diagnosis, care and treatment. I am aware that the practice of medicine is not an exact science and I understand that no guarantee or assurance of beneficial results has been promised or implied as a result of the mentioned diagnostic and therapeutic procedures. I certify that I have read and fully understand this consent for diagnostic and/or therapeutic procedures and treatment. I understand that no guarantees have been made to me about the outcome of this care.

2. RECURRING VISITS: If the services rendered qualify me for recurring status my signature herein shall be valid for care rendered throughout this period.
If during this period, any of my registration information changes, i.e. address, phone, employment, insurance, guarantor, etc., I will notify Optimal Physical Therapy & Performance Institute.

3. RELEASE FROM RESPONSIBILITY FOR PATIENT'S VALUABLES: I hereby certify that I have been advised and fully understand that Optimal Physical Therapy & Performance Institute and its employees are not responsible for any and all personal articles, clothing or cash that I retain in my possession.

4. RELEASE OF INFORMATION: I understand that my medical records are kept in a hard copy and that physicians and persons involved in my care have access to the records. Optimal Physical Therapy & Performance Institute may seek release and verify all or part of the patient's medical record and/or financial records to any person, corporation, or government agency which is or may be liable under a statute, regulation, or contract to the Center, the patient, a family member, or employer of the patient, for all or part of the charges. I consent to the release of my identification and general condition.

5. FINANCIAL AGREEMENT: For and in consideration of services rendered, I agree to make prompt payment to Optimal Physical Therapy & Performance Institute when billed for any and all charges not covered by valid insurance benefits. I understand that I am responsible for any health insurance deductibles, co-payments, and/or coinsurance. If I am classified as a self-pay patient, payment will be requested at time of service. I realize it is my obligation to obtain a referral, pre-certification or a second opinion should it be required prior to services. If Optimal Physical Therapy & Performance Institute, or my insurance carrier, or its intermediaries, deems that medical and/or professional services to be given or already given are not medically necessary and/or non-covered services (e.g. pre-existing conditions), I must pay for those services deemed patient responsibility.

6. MEDICARE-AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: 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 me to release to the Social Security Administration or its intermediaries or carriers or my physician(s) any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physicians or organization to submit a claim to Medicare for payment to me. THE SERVICE I RECEIVE MAY NOT BE COVERED BY MY MEDICARE INSURANCE. IN THE EVENT, I WILL BE RESPONSIBLE FOR ALL CHARGES NOT COVERED.

Estimated coverage information is provided as a courtesy to our patients and is not intended to release them from total responsibility of treatment/payment. _ Please be aware this is not a guarantee of benefits.**_ Actual plan benefits can only be determined upon receipt and processing of your claims.**
(Federal Regulation Code 29, Section 2560.503-1).

Worker's Compensation Clause

The above does not apply to those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied, you will be held responsible for any remaining balance on your account. At the time, our Financial Policy will apply to you.

* I acknowledge receipt of the Patient's Bill of Rights and Responsibilities.

* I understand that if I do not comply with the pre-certification/referral requirements I will be responsible for charges.

* I acknowledge receipt of the Privacy Notice.

* I have read this form, my questions have been answered, and I understand and agree to its content.

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Patient Signature/Authorized Representative Relationship Date