Center for MUSCLE & JOINT Therapy, Inc.

823 Belknap Street
Suite 104
Superior WI 54880
715-394-6355

Name: (Please Print): _____

Privacy Notice Signature

Center for Muscle & Joint Therapy will use and disclose protected health information for the purposes of treatment, payment and health care operations.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices, and is made available at The Center for Muscle & Joint Therapy or by mail upon request. We reserve the right to change the terms of our Notice of Privacy Practices.

You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required to grant your request but if we do, the restriction will be binding on us.

I have been offered a copy of the Privacy Practices of Center for Muscle & Joint Therapy, Inc.

Sign: _____ Date: _____

Print Name of Patient: _____

If you are signing as the patient's representative:

Print Your Name: _____

Describe Your Authority: _____

Billing Authorization Signature

I hereby authorize The Center for Muscle & Joint Therapy, Inc. (CMJT) to furnish information to insurance carriers concerning my illness/accident and I hereby irrevocably assign to CMJT all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. I understand that CMJT will not be held responsible for incidence of cardiovascular mishaps associated with present or undiagnosed conditions during physical rehabilitation.

X_____ Date: _____

Canceling Appointments and NO SHOW FEE Acknowledgement

We realize that on occasion it may be necessary to change scheduled appointments. The Center for Muscle & Joint Policy for canceling is to call and cancel your appointment 24 hours prior to the scheduled time, or as soon as possible. If you MISS more than 2 appointments without calling to cancel prior to the start of that appointment, you will be charged a $25 NO SHOW FEE. This fee will be denied by your insurance carrier (if any) and will be your responsibility to pay. By signing below you indicate that you have been given and understand this information.

X_____ Date: _____