Patient Consent and Billing Form

I, the patient, (or _____ for the patient), do hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatment as ordered by the prescribing physician, his/her assistant(s), consultant(s), necessary in his/her professional judgment. I assume responsibility for discussing and understanding my proposed treatment plan and goals based on the evaluation with my practitioner, as well as expected benefits, potential risks and drawbacks of the evaluation and service and understand treatment does not guarantee an improvement in my current condition.

I authorize Viverant, its employees or agents, to release medical information regarding myself and my current condition(s) to my insurance company for purposes of payment and/or quality reviews; and referring, consulting, treating physicians, or other medical providers as necessary to support continuity of care. This authorization will remain valid until mutually revoked in writing by both the patient and Viverant. I understand that Viverant has made a copy of their Notice of Privacy Practices available for my review, and that I can request a copy at any time in writing or by contacting a Viverant office representative. I give Viverant consent to utilize photos, videos, and/or written/verbal testimonials for marketing purposes, and authorize Viverant to utilize my contact information, such as email addresses or phone numbers, to correspond with me information not considered Protected Health Information (PHI).

Anytime Fitness Club Access Waiver

If being seen at an Anytime Fitness Club, I agree that all activities and use of facilities shall be undertaken by myself at my sole risk. The athletic club shall not be liable for any claims, demands, injuries, damages, or actions whatsoever to me or my property arising out of or connected with the use of any of the services and facilities of the club or the grounds on which the club is located. I expressly forever release and discharge the club from all such claims, demands, injuries, damages, or actions; and from all acts of active or passive negligence on the part of the partnership which owns the club, its partners, agents and employees.

Self-Pay and Membership Agreement

I understand if I choose Viverant's self-pay **ala carte** option, Viverant will not submit charges to my insurance for processing, and payment for self-pay session is due at time of check-in at an hourly rate of $140 per PT/PTA session, and $70 per Pilates, Performance, and/or Nutrition session. If I select Viverant's self-pay services, I understand Viverant is NOT able to withdraw claims already submitted to my insurance to switch to self-pay. Viverant IS able to reprocess self-pay claims to insurance at a fee of $35 per claim.

I understand if I sign up for Viverant's self-pay **membership** plan, in addition to the criteria above, I agree Viverant will retain my credit card on file to process an annual $100 membership fee, and monthly unpaid charges for services rendered at a discounted hourly rate of $125 per PT/PTA session and $65 per Pilates, Performance, and/or Nutrition session for myself and any responsible party on my account.

No-Show Policy

I understand if I schedule and fail to show for an appointment or fail to give 1 business day notice of my cancellation, Viverant may charge me a No-Show fee of $100, in addition to applicable translation / interpreter

charges incurred due to lack of cancellation notice. I agree if I no-show / late cancel two or more times in as many months, my scheduled visits will be canceled and I may be restricted to same-day scheduling only.

Patient General Billing Agreement

I, the patient, (or _____ for the patient), understand I am responsible for communication with my insurance company regarding any copayments, deductibles, or provider information pertaining to my treatment at Viverant. I understand that I am responsible for obtaining any required referrals from primary care clinics. I understand I am ultimately responsible for any charges not covered by third party payers. I attest I am not currently receiving or enrolled in home health services. I agree to notify Viverant in writing if I begin home health services and acknowledge failure to notify Viverant in writing will result in my being financially responsible for services rendered, up to $160 per visit.

I have reviewed or waived desire to review various fee/payment scenarios and understand I am responsible for all outstanding balances. I also understand that any balance on account over 60 days outstanding, after insurance has processed said claim(s), is subject to 3% interest fee per month; any account 90 days outstanding, or in collections for non-payment, will assess a $50 processing fee and will require payment in full prior to further treatment. Any patient payments returned for insufficient funds will be assessed a $20 NSF fee. In addition, I understand I am responsible for any equipment or supplies purchased specifically for my treatment, and I will be billed for any such supplies.

I agree I am responsible for notifying Viverant within 30 days of change in insurance coverage, or termination of existing coverage. If I fail to do so within that timeframe, I will be responsible for full balance due of services rendered. If I notify Viverant of new insurance after services have already been rendered, and insurance will not cover services due to plan-level requirements not being met (such as but not limited to MD Orders, Prior Authorization), I agree to be responsible for full balance due of services rendered.

I hereby agree that I, my assignees, heirs, distributees, guardians, and legal representatives will not make a claim against, sue, or attach the property of Viverant or any agent of Viverant on account of injury or damage resulting from the negligence or other acts, howsoever caused, by any employee, agent, or contractor of Viverant. I hereby release Viverant from all actions, claims, or demands that I, my assignees, heirs, distributees, guardians, and legal representatives now have or may hereafter have for injury or damage resulting from my treatment at Viverant.

If applicable, I authorize third party payment directly to Viverant of the benefits otherwise payable to me. Those charges are not to exceed the regular charges for this period of treatment. If I have sought litigation due to my injury and refuse to provide the appropriate insurance information, I understand that I am required to pay Viverant at the time services are provided. I also understand that if I have filed a Workers' Compensation claim and my claim is denied, I will then be responsible for payment of services as they are received if I do not provide health insurance. I understand I am financially responsible to Viverant for charges not covered by this authorization.