1. Consent to Treat

I hereby authorize **Madison Medical & Sports Rehabilitation Center** and its providers to evaluate and treat me for my medical condition(s). This may include physical examinations, diagnostic testing, procedures, therapies, or other medically necessary care.

I understand that:

- No guarantees have been made as to the results of treatment.
- I may withdraw my consent for treatment at any time.

Signature of Patient/Guardian: _____

Printed Name: _____
Date: _____

2. Patient Financial Policy & Assignment of Benefits

Out-of-Network Practice Statement

Madison Medical & Sports Rehabilitation Center is an **out-of-network practice.** We are currently In-Network with Medicare and Tricare. All other insurances are excepted with Out-of-Network Benefits.

Patient Responsibility

- I understand I am responsible for copays, deductibles, coinsurance, and any balance not covered by my insurance plan.
- If my insurance carrier issues payment directly to me for services provided by Madison Medical, I agree to **immediately endorse the check to Madison Medical** or provide payment in the same amount.
- Failure to forward such payments may result in **collections or legal action.**

MADISON
MEDICAL SPORTS & WELLNESS
Heal Faster. Live Stronger.

Assignment of Benefits

I irrevocably assign to Madison Medical & Sports Rehabilitation Center all rights, benefits, and interests under my insurance plan(s) for services rendered. This assignment includes, but is not limited to:

- The right to collect benefits and payments directly from my insurance plan(s).
- The right to file claims and pursue appeals on my behalf.
- The right to recover penalties, statutory interest, or other remedies for delayed or improper payment.I authorize and instruct my insurance company to pay Madison Medical directly. If my insurance carrier issues payment to me, I agree to immediately endorse and forward it to Madison Medical.

This assignment remains valid for all past, present, and future claims unless revoked in writing. It may not be revoked for services already provided.
I acknowledge that this assignment does not relieve me of financial responsibility for the services provided. If my insurance plan fails to pay in whole or in part, I remain responsible for the balance due.
A photocopy of this assignment shall be considered valid as the original.

Acknowledgement of Financial Responsibility

I acknowledge that I understand the network status of the services and providers at Madison Medical Sports & Rehabilitation Center. I am aware that I should contact my insurance carrier to confirm my plan's coverage and potential costs. I understand that I knowingly and willingly accept full financial responsibility for any care, services, or treatment not covered by my insurance plan, or for which I am otherwise responsible under my policy. If no coverage exists, I agree to pay all charges for the services provided.

Signature of Patient/Guardian: _____
Printed Name: _____
Date: _____

MADISON
MEDICAL SPORTS & WELLNESS
Heal Faster. Live Stronger.

Release of Information

I authorize Madison Medical to release any medical or other information necessary to process claims, secure reimbursement, and pursue appeals.

Acknowledgement

I understand and accept financial responsibility for all services provided by Madison Medical & Sports Rehabilitation Center.

Signature of Patient/Guardian: _____
Printed Name: _____
Date: _____

3. **BCBS Payment Acknowledgement (if applicable)**

Certain **Blue Cross Blue Shield (BCBS)** plans may issue payment for services **directly to you, the patient**, instead of Madison Medical & Sports Rehabilitation Center.

- If you receive a BCBS check for services provided by Madison Medical, that payment is legally owed to Madison Medical.
- You must **immediately endorse the check to Madison Medical** or provide payment in the same amount.
- You must also provide a copy of the Explanation of Benefits (EOB).

⚠ **Important:**
Failure to forward such payments may be considered **insurance fraud** and may result in **collections or legal action**.

Signature of Patient/Guardian: _____
Printed Name: _____
Date: _____