Quantum Shift Physical Therapy and Wellness Center

1201 Wakarusa Dr., Ste. E-1, Lawrence, KS 66049

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____(*Print Name)*, have received a copy of Quantum Shift Physical Therapy and Wellness Center's Notice of Privacy Practices.

_____

Signed Date

Acknowledgement of Receipt of Patients' Rights Policy

I, _____*(Print Name)*, have received a copy of Quantum Shift Physical Therapy and Wellness Center's Patients' Rights Policy.

_____

Signed Date

Assignment of Benefits

Financial Responsibility: I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Quantum Shift Physical Therapy and Wellness Center, LLC (QSPT) and/ or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify QSPT of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company received the claim. I am responsible for the entire bill or balance of the bill as determined by QSPT and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits: I authorized direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Quantum Shift Physical Therapy and Wellness Center, LLC for all covered medical services and supplies provided to me during all courses of treatment and care provided by Quantum Shift Physical Therapy and Wellness Center, LLC (QSPT) and/or all its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by QSPT and will constitute a continuing authorization, maintained on file with QSPT, which will authorized and allow for direct payment to Quantum Shift Physical Therapy and Wellness Center, LLC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me.

_____ _____

Signed Date