Fusion Performance LLC
609 West Johnson Ave
Chesire CT 06409
516-351-6224

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for **Fusion Performance LLC** to furnish medical care and treatment to that is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

FINANCIAL RESPONSIBILITY

Fusion Performance is an out-of-network provider; however, it is the policy of **Fusion Performance** that any in-network benefits will be honored. **Fusion Performance** charges the same rate to a patient (copays, deductibles, and co-insurance) for therapy service as an in-network provider. If the patient has an in-network deductible, they will be charged at our self-pay rate until their deductible is met. Coinsurance will also be based on our self-pay rate. Patients that do not have out-of-network benefits or insurance coverage will be charged at our self-pay rate.

***Blue Cross Blue Shield Patients:** Please note that due to **Fusion Performance LLC** being an out-of-network provider with Blue Cross Blue Shield, insurance checks will be sent directly to you. It will be your responsibility to provide any checks to **Fusion Performance LLC.** If you do not provide the check to **The Fusion Performance LLC,** you will be invoiced for the amount. If the check is lost, it is your responsibility to contact your insurance provider to re-issue a new check.

AUTHORIZATION BENEFIT ASSIGNMENT

I agree to pay any applicable co-payments at the time of service and I understand I will be responsible for any coinsurance and/or deductibles. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

A photocopy of this authorization is to be considered as valid as the original.

By my signature, I authorize **Fusion Performance LLC**, to release all information necessary, including medical records, to secure payment.

CONSENT FOR USE, DISCLOSURE, AND RELEASE OF HEALTH INFORMATION

I understand that by signing this consent, I am giving my consent to **Fusion Performance LLC** to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I authorize **Fusion Performance LLC** to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to **Fusion PerformanceLLC** from my insurance carrier or third-party payer.

SIGNATURE FOR CONSENT

By my signature below I acknowledge that I have read, understand and agree to the terms and conditions contained in this agreement.

Print Name: _____

Signature: _____ Date: _____