The Recovery Project, LLC

Neurological - Oncology - Orthopedic - Sports Rehabilitation

The Recovery Project, LLC
11878 Hubbard St. Livonia, MI 48150
15500 19 Mile Road- Suite 330, Clinton Twp, MI 48038
3960 Patient Care Dr.-Suite 117, Lansing MI 48911

CONSENT FOR TREATMENT

Patient Name:_____

1. **CONSENT:** I consent to therapeutic treatment as deemed necessary by my providers. I recognize the patient is under the care of his/her attending provider and TRP personnel render services to patients pursuant to the instructions of the attending provider. I know if I have questions about my medical care, I should be sure to ask the staff about them. I know it is up to me to tell the staff about any health problems or allergies I have. I must also tell the staff about drugs or medications I am taking. Further, I acknowledge, agree and understand that: physical therapy, conditioning, fitness and related activities can be hazardous and may result in injury to others or me. In consideration of the permission given to use these facilities and undergo treatment, I agree as follows:

I assume all risks of injury incurred or suffered while undergoing treatment, conditioning, fitness or using the equipment of TRP while on and/or upon the premises of TRP and/or in my home. I release, covenant not to sue and hold harmless TRP, its agents, employees, officers, members, independent contractors, lessors or anyone connected with TRP, of and from any claim, liability, damages, costs or cause of action which I may have or in the future could have as a result of injuries or damages sustained or incurred while undergoing treatment, conditioning, fitness or using the equipment of TRP while on and/or upon the premises of TRP and/or in my home.

2. **CONTRACT FOR SERVICES:** I agree to pay in full any and all charges for TRP and provider services not covered by insurance benefits. I assign and authorize payment to be made directly to TRP and/or providers of all healthcare benefits otherwise payable to me. I understand that providers may bill separately. I certify that any and all information provided by me in furtherance of my application for healthcare benefits are true. TRP reserves the right to perform a credit check if needed.

If I default or do not pay for services provided, I acknowledge and agree that TRP is entitled to recover the full amount of any debt owed for services provided and is entitled to recover from me all collection expenses, including litigation costs, and reasonable attorney's fees incurred for the purpose of securing payment, whether litigation is instituted or not. Collection expenses and/or attorney fees include all costs, charges and fees incurred by TRP to pursue the collection, whether litigation is instituted or not.

I agree that in order for TRP to service my account or to collect any amounts I may owe, TRP or a vendor acting on its behalf, may contact me by telephone at any telephone number associated with my account, including cellular telephone numbers. I agree that TRP or a vendor acting on its behalf may also contact me by U.S. mail or e-mail, using any e-mail address I have provided. I acknowledge and agree that methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

3. **RELEASE OF INFORMATION:** I authorize TRP and each provider who treated me, to release to any party responsible for payment for the patient's care, such as information from the medical records as is required in order for TRP to obtain payment and to any participants in audits of such payments. This authorization to release information for purposes of payment includes all records, including those records protected under regulation in Code 42 of the Federal Regulations, Part 2, and Michigan Public Act 488 of 1988 of Alcohol and Drug Abuse and or Treatment, records of psychological services, and records of social services, including communications regarding communicable diseases, including Acquired Immune Deficiency Syndrome (AIDS), HIV infections, AIDS Related Complex, and Hepatitis A, B or C. This authorization is effective only so long as necessary to obtain complete payment or reimbursement and will end when complete payment or reimbursement is received. This authorization to release medical information may be withdrawn as it applies to alcohol or drug abuse only, except such information regarding alcohol and drug abuse as has been released before withdrawal. In the event I am transferred from TRP to be treated at a hospital, extended care, or other facility I hereby consent and direct medical and other information be released by TRP as may be necessary or useful in obtaining further care and treatment. I further specifically authorize any and all other hospitals and healthcare providers whom I have received services in the past to release the before specified medical information to TRP upon written request for same, but only during such time as I am a patient of TRP.

4. **NO GUARANTEE:** I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatment. I understand that no contract, warranty, guarantee, or promise concerning the results of medical service is made. This consent to treatment form is not a contract, nor is it an offer to contract, nor is it an acceptance of an offer. I further understand and agree that TRP will not be liable for the loss or damage to any personal property.

5. **NOTICE OF PRIVACY PRACTICES:** I have been informed of the HIPAA Notice of Privacy Practices for The Recovery Project. This notice has been made available to me via hard copy.

Additions, deletions or changes to this form are not permitted or considered. Photo static copies of this agreement, and the signature below, shall be considered the same as the original. I HAVE READ THIS FORM. IT HAS BEEN FULLY EXPLAINED TO ME, AND ALL OF MY QUESTIONS ABOUT THE FORM HAVE BEEN ANSWERED. I UNDERSTAND ITS' CONTENTS.

SIGNATURE OF PATIENT/GUARDIAN	WITNESS	DATE

COVID-19 Informed Consent Form

I, _____, knowingly and willingly consent to have therapy services provided by The Recovery Project during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and may still be contagious. It is impossible to determine who has the virus and who does not given the current limits in virus testing.

I recognize that The Recovery Project is closely monitoring the COVID-19 situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19.

I am aware of the CDC guidelines and that if I fall into one or more of the following categories, I am at higher risk of obtaining the virus.

1. Individuals currently using a ventilator or oxygen to assist with respiration.
2. Individuals with a history of or managing respiratory illness concurrently with their primary diagnosis.
3. Individuals with immunosuppression via medication or other condition. i.e. Cancer/autoimmune disease.
4. Individuals over the age of 65.

I confirm that I am not presenting with any of the following COVID-19 symptoms:

- Fever
- Shortness of Breath
- Sore Throat
- Cough
- Diarrhea

I acknowledge that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus.

I verify I have not been in close contact in the last 14 days with an individual diagnosed with COVID-19.

_____

Patient or Person Authorized to Sign for Patient Date

Witness_____ Date_____

11878 HUBBARD ST.
LIVONIA, MI 48150
T 734-953-1745 F 734-953-1743

15500 19 MILE ROAD, SUITE 330
CLINTON TWP, MI 48038
T 586-412-0016 F 586-412-0117

3960 PATIENT CARE DRIVE, SUITE 117
LANSING, MI 48911
T 517-325-0996 F 517-882-8940

WWW.THERECOVERYPROJECT.NET FACEBOOK.COM/THERECOVERYPROJECT.LLC/ INSTAGRAM: @RECOVERYPROJECT

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TESTIMONIAL CONSENT AND RELEASE

Permission is hereby irrevocably granted to The Recovery Project, LLC to use, copy, distribute, and display the Images (as such term is defined below) for use in newsletters, e-blasts, press articles, web sites related to The Recovery Project, brochures, other promotional pieces, advertisements, social media and/or the internet, with primary focus to promote The Recovery Project, without restriction as to frequency or duration. The term "Images" shall mean any or all of the following: my name and/or photographic likeness, still pictures, video clips, audio clips, medical descriptions of the image content created by The Recovery Project, statements made by me in the form of testimonials or otherwise, and any reasonable modifications of the foregoing. I hereby grant to The Recovery Project all rights, title and interest in and to the Images, including any copyright therein.

I certify that I am 18 years of age or older and that the statement(s) made by me regarding The Recovery Project reflect in spirit and content my true experience with the product or service mentioned.

I waive all rights against and release The Recovery Project from any claim or cause of action, whether now known or unknown, for defamation, invasion of the right of privacy, publicity or personality, based upon or relating to the use of any Images pursuant to this Consent. I understand that, although The Recovery Project will endeavor to use the Images in accordance with standards of good judgment, The Recovery Project cannot guarantee that any further dissemination of the Images will be subject to supervision or control by The Recovery Project. Therefore, I release The Recovery Project from any and all liability related to dissemination or distribution of the Images.

This Consent and Release shall be binding upon my heirs, next of kin, executors, and personal representatives. It shall also be binding upon and inure to the benefit of The Recovery Project, LLC and its successors and assigns.

☐ No, I do not consent. Name: _____ Date: _____

☐ Yes, I consent. Name: _____

Street Address: _____

City, State, Zip Code: _____

Signature: _____

Date: _____

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HIPAA Authorization for Disclosure of Health Information to Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: _____ Relationship: _____

Address: _____

Phone #: _____ Email: _____

Health Information to be disclosed, upon the request of the person named above (check A, B, C, or D):

- ☐ A. Do **not** disclose any health information to family or friends.
- ☐ B. Disclose my complete health record (including but not limited to diagnoses, prognosis, treatment, patient status, general/emergency announcements, scheduling, billing for all conditions)
- ☐ C. Disclose my health record, as above, BUT do not disclose the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify): _____
- ☐ D. Disclose ONLY information and communications related to the following (check as appropriate):
  - ☐ Patient Status (Active / Inactive)
  - ☐ General/Emergency Announcements by The Recovery Project
  - ☐ Scheduling
  - ☐ Billing / Payment of a Bill

Unless I revoke it, this authorization shall be effective until:

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____

NOTE: You may revoke this authorization at any time by notifying your health care providers in writing.)

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ Electronic (including email, text, online portal, etc.)
- ☐ Printed/Paper Copy
- ☐ Verbal Communication (in person, over the phone, video conference, etc)

_____ _____

Printed Name of the Individual Giving this Authorization — Date of Birth

_____ _____

Signature of the Individual Giving this Authorization — Date of Signature

The Recovery Project, LLC

Patient Expectations

Your Initial Visit

Your first visit will last about 90 minutes – please allow approximately 30 minutes for registration/paperwork and 60 minutes for the initial evaluation. New patient paperwork is very comprehensive and will provide important information to your therapist about your injury, current functional limitations, and medical history. If your initial evaluation is at a TRP clinic, please arrive **30 minutes** prior to your scheduled appointment time. For your initial visit, be sure to have the following:

- All insurance card(s) and any additional insurance information
- Your photo identification card/driver's license
- A list of all prescription and non-prescription medicines/supplements with dosage amounts

Your Therapy Appointments

All patients are under the care of a licensed physical therapist, occupational therapist and/or speech therapist for every appointment at The Recovery Project with the support of clinical staff, including licensed assistants, licensed athletic trainers, personal trainers, and rehab technicians where indicated. For your initial visit, your therapist will evaluate your condition and identify the source of your pain, or physical injury. Your therapist will examine the muscles, nerves, tendons, ligaments, bones, and tissues as they pertain to your physical complaints or limitations.

After your initial evaluation, your therapist will develop a treatment program that will often address physical deficits, such as strength, posture, flexibility, neurological status, joint motion, and functional limitations with activities of daily living. Therapy treatment may include the use of manual therapy techniques and exercise. Therapeutic modalities may be used to decrease swelling, decrease pain and/or soothe injured muscles. You will receive instruction on a home exercise program. The home exercise program may include education on proper body mechanics, posture to prevent re-injury, exercise instruction, cold/heat therapies and general self-care. Your therapist will plan, implement, and monitor your progress throughout the treatment program.

For your safety, if you are dependent on a ventilator, your trained staff member must be with you at all times during your treatment sessions.

The Recovery Project utilizes resuscitation and emergency services for all emergencies regardless of the patient's advanced directive status.

The Recovery Project is a teaching facility. We have masters and doctorate level residents that participate in evaluation and treatment sessions. These residents are under the direction and supervision of licensed therapists at all times.

How You Can Make the Most of Your Appointments

- Be ready 5 minutes before each appointment.
- Check in at the FRONT DESK every time for in clinic appointments.
- Pay your co-pay at each visit at the beginning of your appointment.
- Provide a safe environment for your treating therapist, if being treated in the home.
- Wear comfortable clothes and tennis shoes.
- Eat a proper meal before your appointment.
- Be hydrated – drink plenty of water always.
- Make sure to bring any braces and walking devices used regularly to each appointment.
- Work on your personal home exercise program as directed by your therapist.

Scheduling

Appointments are normally scheduled for 60 minutes per discipline (physical therapy, occupational therapy, speech therapy and massage therapy). Most clients are treated 2 or 3 times a week. Your appointments will re-occur on the same days and times each week.

Appointments are scheduled for 4 to 6 weeks (orthopedic) or 6 to 12 weeks (neurological) depending on the therapist's evaluation of your needs. Your length of stay depends on your treatment progress. Your therapist will re-evaluate your progress every 4 weeks to determine whether to extend therapy beyond the current schedule.

Authorizations

Depending on your insurance plan, a pre-authorization may be required for all appointments. If this is a requirement, there may be a delay in your schedule or small gaps in appointments from one authorization to the next. Please know our staff is doing everything they possibly can do to get the appropriate amount of therapy approve.

Cancellations/No-Show Policy INITIAL HERE

We expect our patients to attend each scheduled therapy session; however, we understand patients may occasionally need to cancel or reschedule appointments due to an illness, transportation problems, or other unexpected difficulties.

We require at least 24-hour cancellation notice. Patients are allowed 2 no show/no calls or 3 cancelled appointments before being taken off schedule. If a cancellation is made less than 24 hours before a scheduled appointment, the cancellation will count as a no show. If a cancelled appointment is rescheduled during the same week, the cancellation will not be held against you.

No Show Fee

Any patient who fails to show, cancel, or reschedule an appointment and has not contacted our office prior to the appointment will be considered a No Show and charged a **$25.00 fee per session**. Some clients are scheduled for more than one session in a day. Please note, a fee will be charged for each session missed in one day. The fee is charged directly to the client and is not covered by the insurance company.

If you are unable to keep an appointment, please call the clinic you are scheduled to attend:

- Clinton Township: 586-412-0016
- Lansing: 517-325-0996
- Livonia: 734-953-1745
- Residential Care: 734-601-2105

Payments & Billing INITIAL HERE

Co-Pay, Co-insurance, Deductible and Fees

Your co-pay, per visit deductible estimate, and per visit therapy fees are due at the time of visit and collected at check in. Any co-insurance and remaining deductible balances will be invoiced to you after the insurance company processes your claims. Payments may be made by cash, check or credit card (VISA, Mastercard, AMEX, and Discover). Failure to pay your co-pay, co-insurance, deductible and/or fees will result in discharge.

Therapy Benefits Used Prior to TRP

Your insurance company may limit the number of therapy visits they will pay for each year. If you use more than the number of visits covered by your insurance company, it is your responsibility to pay for those visits. Please inform the clinic receptionist or scheduler if you received therapy at another clinic this year.

Supplies

While not all treatment options are required for therapy, some are highly recommended and may require purchasing supplies not covered by insurance. You may be able to get reimbursed for this expense from your insurance company or through a flexible spending account. Supply prices are as follows:

- Valutrode Electrodes $ 5.00 per pack
- Platinum Electrodes $10.00 per pack
- Vital Stim Electrodes $10.00 per pack
- Kinesio Tape $15.00 per roll

Patient Billing Statements

Billing for therapy services is completed on a monthly basis and at the end of each calendar month. We will submit all charges for the month to your insurance company and wait for the Explanation of Benefits (EOB)/payment from the insurance company before we bill the balance, if any, to you. It will usually take 2 months from the time of service to receiving a Billing Statement if you do not have a secondary insurance plan. The charges you receive should coincide with the benefits we covered with you when you scheduled your appointment. Payment is due in full within 30 days of receiving a Billing Statement. If you need to make payment arrangements, we will work with you to set up a mutually agreeable payment plan.

Update Your Account

It is your responsibility to inform us of any changes or planned changes involving the following:

- Insurance
- Contact Information
- Case Manager
- Adjustor
- Physician
- Litigation Status

Delayed notification of any of these changes that result in rejections are the financial responsibility of the patient.

Patient Surveys

The Recovery Project strives to provide extraordinary service and therapy to all our patients. We want to hear about your TRP experience. Patients will be emailed surveys after their initial evaluation, 2-3 weeks into therapy, and at discharge. Thank you for your candid feedback!

Questions

If at any point you have questions regarding your therapy, schedule, insurance, or billing, please contact The Recovery Project so we may assist you or direct you to a person who can.

Patient Name: _____

Patient Signature: _____ Date: _____

The Recovery Project, LLC

PATIENT HISTORY FORM

PATIENT DEMOGRAPHICS

FULL NAME:_____ DATE OF BIRTH:_____

GENDER: ☐ FEMALE ☐ MALE ☐ NON-BINARY RACE: ☐ Asian ☐ Alaskan/American Indigenous ☐ Black/African American ☐ Hawaiian/Pacific Islander Indigenous ☐ Hispanic/Latino ☐ White

HOME ADDRESS:_____

CITY:_____STATE:_____ ZIP CODE:_____EMAIL:_____

PRIMARY PHONE:_____ ☐ HOME ☐ MOBILE ☐ WORK ☐ SPOUSE ☐ CAREGIVER ☐ OTHER

SECONDARY PHONE: _____ ☐ HOME ☐ MOBILE ☐ WORK ☐ SPOUSE ☐ CAREGIVER ☐ OTHER

EMERGENCY CONTACT INFORMATION *(different than above)*

Name: _____ Phone#: _____Relationship: _____

GUARDIAN/POWER OF ATTORNEY STATUS: Self____ Guardian____ Power of Attorney ____

GUARDIAN/POA NAME: _____ Phone#: _____Email: _____

REFERRAL: Who referred you to The Recovery Project?_____

Please describe how you found us (circle): Print Ad___ Friend___ MDA___ Doctor___ Case Manager___ TRP Wellness___ Google Search___ TRP Website___ Senior Event___ Returning Client___ Other_____ -____

SOCIAL HISTORY

EDUCATION: HIGH SCHOOL COLLEGE SOME COLLEGE TRADE SCHOOL OTHER: _____

DO YOU DO ANY FORM OF REGULAR EXERCISE EVERY DAY? YES NO IF YES, HOW MUCH? _____

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED OTHER: _____

OCCUPATION: _____HOW LONG AT CURRENT EMPLOYER: _____

WHO DO YOU LIVE WITH?_____ WHERE DO YOU LIVE? private home___ private apartment___ rented room___ nursing home___ assisted living/group home___ Other_____

LIST ANY PHYSICIANS AND/OR PRACTIONERS YOU CURRENTLY SEE

NAME Physician: _____ PHONE NUMBER: _____

NAME Case Manager: _____ PHONE NUMBER: _____

MEDICAL HISTORY- SELF/FAMILY

DISEASE/SYMPTOMS	YES	NO	Sibling/parent/grandparent? If so, list family member(s)
ANXIETY			
ARTHRITIS			
ASTHMA			
ATRIAL FIB			
BOWEL/BLADDER INCONTINENCE			
BROKEN BONES/FRACTURES			
CANCER: (TYPE)			
CHEST PAINS (ANGINA)			
DEPRESSION			
DIABETES			
DIZZINESS			
HEART ATTACK			
HEART DISEASE			
HIGH BLOOD PRESSURE			
MIGRAINES			
MULTIPLE SCLEROSIS			
OSTEOPOROSIS			
OSTEOPENIA			
PAIN: (BODY PART)			
PARAPLEGIA			
PARKINSON DISEASE			
QUADRIPLEGIA			
SEIZURES			
SPINE PROBLEM			
STROKE/CVA			
VISION CHANGES			
HEREDITARY DISEASE: TYPE			
OTHER:			

LIST ANY CURRENT MEDICAL PROBLEMS OR CHRONIC ILLNESSES

including any diagnoses for which you see a physician or take a medication.

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

LIST ANY MEDICATION THAT YOU CURRENTLY TAKE, INCLUDING OVER-THE-COUNTER

NAME	STRENGTH	DIRECTION	PRESCRIBED BY

LIST ANY PAST SURGERIES OR HOSPITALIZATIONS

1. _____ YEAR: _____ 4. _____ YEAR: _____

2. _____ YEAR: _____ 5. _____ YEAR: _____

3. _____ YEAR: _____ 6. _____ YEAR: _____

HOW WERE YOU INJURED? ◯Auto Accident ◯Work ◯Progressive Disease ◯Other _____

DATE OF INJURY/ONSET: _____

HAVE YOU PARTICIPATED IN PT/OT/SLP IN THE PAST? YES/NO IF YES, PLEASE LIST AND DATE:

_____

PLEASE INDICATE IF YOU DO OR DO NOT NEED HELP PERFORMING THESE ROUTINE TASKS (CONTINUED)

MANAGING MONEY
(KEEPING TRACK OF EXPENSES/PAYING BILLS) ☐ YES ☐ NO IF YES, WHO HELPS? _____

WALKING ACROSS THE ROOM
(INCLUDES USING A CANE OR WALKER) ☐ YES ☐ NO IF YES, WHO HELPS? _____

MODERATELY STRENUOUS HOUSEWORK
SUCH AS DOING THE LAUNDRY ☐ YES ☐ NO IF YES, WHO HELPS? _____

SHOPPING FOR PERSONAL ITEMS LIKE
TOILETRIES OR MEDICINES ☐ YES ☐ NO IF YES, WHO HELPS? _____

PLEASE INDICATE IF YOU DO OR DO NOT NEED HELP PERFORMING THESE ROUTINE TASKS

FEEDING YOURSELF	YES	NO	IF YES, WHO HELPS? _____
GETTING FROM BED TO CHAIR	YES	NO	IF YES, WHO HELPS? _____
GETTING TO THE TOILET	YES	NO	IF YES, WHO HELPS? _____
GETTING DRESSED	YES	NO	IF YES, WHO HELPS? _____
BATHING OR SHOWERING	YES	NO	IF YES, WHO HELPS? _____
TAKING YOUR MEDICINES	YES	NO	IF YES, WHO HELPS? _____
PREPARING MEALS	YES	NO	IF YES, WHO HELPS? _____
SHOPPING FOR GROCERIES	YES	NO	IF YES, WHO HELPS? _____
DRIVING	YES	NO	IF YES, WHO HELPS? _____
CLIMBING A FLIGHT OF STAIRS	YES	NO	IF YES, WHO HELPS? _____

FALL RISK

ARE YOU AFRAID OF FALLING? YES NO SOMETIMES

HAVE YOU FALLEN IN THE PAST YEAR? YES NO

AUTHORIZED SIGNATURE:_____ DATE:_____

The Recovery Project, LLC

PATIENT NAME: _____

MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW
GUARDIAN/POWER OF ATTORNEY STATUS AND CONTACT INFORMATION FORM

On May 25, 2017, the Michigan Supreme Court issued a landmark decision in the case of *Covenant Medical Center, Inc, v. State Farm Mutual Automobile Insurance Company*. In a 5-1 decision, the Court took away significant legal rights of healthcare providers who care for auto accident survivors. The Court held that healthcare providers do not have a right under the Michigan No-Fault Act to sue no-fault insurance companies for services rendered to auto accident patients. Rather, the Court decided that the patient is the only person that has the direct legal right to sue the no-fault insurance company for non-payment of no-fault benefits.

In order to give healthcare providers the right to pursue payment from no-fault auto insurance companies, patients in the State of Michigan can give ("assign") their right to sue to a healthcare provider through an Assignment of Rights form. Approximately every other month, while the above listed individual is a patient of The Recovery Project, we will ask the patient/guardian/power of attorney to sign and date an Assignment of Rights form. In an effort to simplify this tedious process, please complete the following Guardian/Power of Attorney contact information to let us know your preferred contact method.

Please complete each field.

GUARDIAN/POWER OF ATTORNEY STATUS: Self____ Guardian____ Power of Attorney____

GUARDIAN/POA NAME: _____ PHONE #: _____

IF GUARDIAN/POA, RELATIONSHIP TO PATIENT: _____

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ EMAIL: _____

How would you like to receive the Assignment of Rights Form going forward? Mail _____ Email _____

Patient / Guardian / Power of Attorney Signature: _____ Date: ____ /____ /____

The Recovery Project, LLC

MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF RIGHTS FORM

I, _____, ("Assignor"), hereby assign to The Recovery Project, LLC ("Assignee") all rights, privileges and remedies to payment for health care services, products or accommodations ("services") provided by Assignee to Assignor to which Assignor is or may be entitled under Chapter 31 of the Insurance Code (MCL 500.3101, et seq), the No-Fault Act.

The assignment as set forth above is for all services provided to Assignor by Assignee prior the time of Assignor's execution of this agreement. It is agreed that this is not an assignment of future benefits.

Assignor hereby certifies that Assignor has incurred charges for services actually provided by Assignee for which the rights, privileges and remedies for payment are hereby assigned.

Assignor hereby requests and accepts Assignee's assumption of the burden of pursuit of payment from any person or entity from whom payment for the above-referenced services is or might be owed under Chapter 31 of the Insurance Code (MCL 500.3101, et seq), the No-Fault Act as adequate consideration for this Assignment. This assignment is not revocable by Assignor so long as Assignee's performance as described in this paragraph is underway or by written agreement of the Assignee.

Assignor and Assignee agree that in the event any terms or provisions of this agreement are declared invalid or unenforceable by any Court or Federal or State Government Agency having jurisdiction over the subject matter of the agreement, the remaining terms and provisions that are not affected thereby shall remain in full force and effect.

_____ _____

Print Name of Patient Signature of Patient

_____ _____

Print Name of Legal Guardian/POA Signature of Legal Guardian/POA

_____

Date

☐ No, I do **not** wish to assign my rights to The Recovery Project for the therapy services provided to me. If my no-fault auto carrier does not pay The Recovery Project for services provided to me, I will be responsible for pursuing payment from the no-fault auto insurance company.

_____ _____

Print Name of Patient Signature of Patient/Guardian/POA

_____

Date