TOTAL HEALTH & REHABILITATION, INC.

AUTHORIZATION AND CONSENT FORM

Patient Name____
Please Print

__________ **INSURANCE ASSIGNMENT OF BENEFITS AND RIGHTS**
Initials This is a direct assignment of my rights and benefits under any applicable policy of insurance. I hereby authorize payment of medical benefits directly to Total Health & Rehabilitation, Inc. for any physical therapy services rendered to me and/or my dependent(s). This includes an assignment of any cause of action that might accrue against any such insurance carrier for its failure to pay insurance benefits. I understand that I am responsible for all costs of treatment, regardless of insurance coverage.

__________ **CONSENT FOR TREATMENT / CONFIDENTIALITY AGREEMENT**
Initials I hereby authorize and release Total Health & Rehabilitation, Inc. and all designated assistants to administer treatment, physical examination, and any other services deemed necessary for my care. I agree to maintain the confidentiality of the other patients of the facility and not to disclose to anyone anything discussed at the facility by anyone other than me.

__________ **AUTHORIZATION AND RELEASE OF PROTECTED HEALTH INFORMATION**
Initials I hereby request and authorize Total Health & Rehabilitation, Inc. to disclose all or any part of my protected medical records and billing statements for the purpose of review and evaluation in connection with my healthcare, processing claims, securing payment of benefits, or settling legal claims regarding liability cases or worker's compensation cases if applicable. This authorization includes but is not limited to insurance companies, medical service companies, automobile carriers, worker's compensation carriers, health care providers, health care clearinghouses, welfare funds, disability offices, representing attorneys, and employers. I understand that I have the right to revoke this authorization in writing at any time and that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

__________ **FINANCIAL RESPONSIBILITY**
Initials I understand that I am responsible for notifying Total Health & Rehabilitation, Inc. of any insurance coverage and insurance changes. I understand that verification of benefits is not a guarantee of payment and that I am responsible for any balance not covered by insurance. I acknowledge that failure to pay my balance or make payment arrangements on balances greater than 120 days may result in my discharge from this facility and my account being referred to a collection agency and the credit bureau.

I hereby certify that I have read this document; I understand its content; and I agree to its terms. I also certify that I have provided Total Health & Rehabilitation, Inc., with all necessary information to process my insurance claims and that the information provided is true and complete to the best of my knowledge.

X____ Date _____/_____/_____
Signature of Patient / Parent or Legal Guardian

PERMISSION TO TREAT A MINOR (if applicable)
I hereby authorize and release Total Health & Rehabilitation, Inc. and all designated assistants to administer treatment, physical examination, and any other services deemed necessary to my ________________________.
Indicate relationship to child

Name of Parent or Legal Guardian____.
Please Print

X____ Date _____/_____/_____
Signature of Parent or Legal Guardian

A Photocopy Of This Document Is To Be Considered As Valid And Enforceable As The Original

02/17/2016 dlf