PATIENT CONSENT FORM

Welcome to Therapy. We are committed to providing comprehensive rehabilitation services that increase independence and quality of life. In order to initiate services, we need your signature to authorize treatment, release of information and reimbursement.

Patient: ______________________________

Facility: ______________________________

Physical Therapy   Occupational Therapy   Speech-Language Pathology

Authorization for Treatment

- I consent and authorize rehab department render therapy set forth above as ordered by my physician.
- Unless treatment would require isolation, I authorize the therapy to be provided in areas not totally isolated from other patients and personnel.

Release of Information

- This authorization, or copy of same, authorizes the release to the facility of any medical information necessary for treatment and/or to process claims for services rendered.
- This authorization authorizes the facility to disclose any information furnished by, or obtained by the facility in connection with patient's treatment (including information concerning a related Medicare claim), to any physician, governmental Agency (including the Social Security Administration or any of its intermediaries or carriers), insurance company or health care facility requesting such information.
- Patient and Patient Representative agree to execute any documents and perform any acts that the facility may reasonably request.
- The undersigned warrants and represents that attached hereto are originals or certified Copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of Patient.

Reimbursement Coverage

- Patient hereby assigns to the facility all private medical insurance benefits (primary and secondary, including med.gap providers) or other benefits to which Patient may be entitled for any therapy services rendered by the facility.
- Patient authorizes and directs the facility to apply and file for all such benefits on behalf of Patient.
- Patient agrees that he/she shall be jointly and severally financially responsible or any portion of the facility's invoice that is not paid, including but not limited to (i) any applicable deductions or co-insurance, (ii) any non-insured or non-covered services authorized, or (iii) any charges in excess of payment limitations imposed by third payors, except in the event of Medicare denial or Medicaid eligible recipients.
- Patient authorizes the facility to represent Patient during the appeals process in the event of a denial of Medicare benefits.

I have received the "Notice of Exclusions from Medicare Benefits" (NEMB) and understand the financial responsibility for non-covered services. ☐ Non-applicable

______________________________ Date: __________

Signature of Patient / Patient Representative

Witness: ______________________________ Date: __________

If someone other than Patient has signed, state name and relationship to Patient:

Name: ______________________________ Relationship to Patient: __________

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