CONSENT FOR TREATMENT-RELEASE OF INFORMATION-HIPPA PRIVACY NOTICE-FINANCIAL AGREEMENT

Patient Name: _____ Date: _____

CONSENT: I do hereby agree and give my consent for **Performance Rehab** to furnish Therapy Treatment. _____(Please initial)

Performance Rehab has my permission to allow students to observe my treatment and care. Yes _____ NO _____(check yes or no)

RELEASE OF INFORMATION: I agree that **Performance Rehab** may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medial records, to any third party payers, including, but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers. This includes appropriate release and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other health care providers when necessary for my treatment and general health. While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

PLEASE LIST BELOW ANY OTHER PEOPLE WITH WHOM YOU AUTHORIZE OUR OFFICE TO DISCUSS YOUR PHI and/or BILLING INFORMATION.

Name: _____ Relationship _____ PHI _____ Billing _____

Name: _____ Relationship _____ PHI _____ Billing _____

HIPAA PRIVACY NOTICE: I acknowledge that I have received the HIPAA Privacy Notice and have had the opportunity to review its content. _____ (Please initial)

FINANCIAL POLICY STATEMENT: As a courtesy we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payments at the time of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly remit same to **Performance Rehab.**

The above does not apply for those patients that are considered Workers' Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

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.

Note: Estimated coverage information is provided as a courtesy to our patients, but it is not intended to release them from total responsibility for their account balance.

*******ARE YOU BEING TREATED AS A RESULT OF AN AUTO ACCIDENT: YES _____ NO_____**
(If yes, have you supplied Performance Rehab with your claim information?)
*******ARE YOU BEING TREATED AS A RESULT OF A WC ACCIDENT: YES _____ NO _____**
(If yes, have you supplied Performance Rehab with your claim information?)
*******ARE YOU BEING TREATED AS A RESULT OF AN ACCIDENT OF ANY KIND: YES _____ NO _____**

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____
Patient/Guardian/Responsible Party **Date**

_____ _____
Performance Rehab Witness **Date**

PERFORMANCE REHAB

Patient Information				
Patient Name			Appt. Date	
Address	City		State	Zip
Home Phone	Cell Phone		Email	
Date of Birth	SSN	Gender: M F	Marital Status: M S D W	
Emergency Contact:	Phone #		Relationship	

Guarantor Information			
Name	Contact #	Gender: M F	
Address	City	State	Zip
Date of Birth	SSN # (REQUIRED)	Relationship to Patient	

Insurance Policy Holder Information			
Name	Contact #	Gender: M F	
Address	City	State	Zip
Date of Birth	SSN #	Relationship to Patient	
Employer Name		Employer Phone #	

Secondary Insurance Policy Holder Information			
Name	Contact #	Gender: M F	
Address	City	State	Zip
Date of Birth	SSN #	Relationship to Patient	
Employer Name		Employer Phone #	

Additional Information			
Workers Comp	Date of Injury	WC Claim #	
Auto Insurance	Date of Injury	Claim #	
Insurance Adjuster	Phone #	Fax #	
Case Manager	Phone #	Fax #	

PATIENT INFORMATION FORM

Patient Signature

Date