Consent For Treatment, Insurance / Reimbursement and Privacy Rights

Name _____(Please Print) DOB_____

I hereby authorize *ProCare Rehabilitation LLC* through its duly authorized agents, to perform or have performed upon me, or the above named patient, such assessment and treatment procedures as are deemed necessary and/or appropriate.

Patient/Parent/Guardian _____Date _____

I understand and agree that (regardless of my insurance status): I am financially responsible for my account for any professional services rendered that are not otherwise paid or reimbursed. I hereby authorize my insurance company assign my benefits directly to ProCare Rehabilitation LLC benefits payable to me. I also agree to be responsible for payment of all services rendered on my behalf for my dependents. I understand and agree that should my account be turned over to a collection agency, I may be responsible for up to an additional 32% of the unpaid balance.

Patient/Parent/Guardian _____Date _____

PRIVACY NOTICE: I have been offered a copy of the NOTICE of PRIVACY PRACTICES and have _____accepted /_____declined a copy.

In addition to the Notice of Privacy Practices, I hereby allow *ProCare Rehabilitation* to disclose information regarding my care to the following individuals:

Name *Relationship*

1._____

2._____

3._____

Patient/Parent/Guardian _____Date_____

***Medicare patients*: I have been informed about Medicare benefits and the Outpatient physical therapy guidelines related to Medicare Part B.**

Patient/Parent/Guardian _____Date _____