

**CONSENT TO EVALUATE AND TREAT**

I do hereby consent to the evaluation and treatment by PALISADES REHABILITATION SERVICES therapists. I understand that it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the result that may be obtained from such treatment.

**NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT (HIPPA)**

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-ups among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge receipt of the REHABILITATION SERVICES Notice of Privacy Practice, which I received today.

**RELEASE OF MEDICAL RECORDS**

Authorization is given to PALISADES REHABILITATION SERVICES, PC. to release a copy of medical records to my insurance carrier, Medicare, third party payors or others responsible for insurance claims and investigations. This includes release of information to other health care practitioners and includes the following forms of medical information: verbal, written, video, photographic, e-mail, and FAX transmission.

**ASSIGNMENT OF BENEFITS**

I hereby authorize payment of insurance benefits directly to PALISADES REHABILITATION SERVICES, PC. which would otherwise be payable to me. **In the event my insurance company forwards payment to me I agree to forward reimbursement** for therapy services to PALISADES REHABILITATION SERVICES, PC. I acknowledge that payments for services rendered are my responsibility as the patient presenting for treatment (or his/her legal guardian).

**FINANCIAL AGREEMENT**

The undersigned agree, whether signed as patient, legal guardian, or authorized agent, that s/he individually obligates her/himself to pay for services rendered in accordance with the rates and terms of PALISADES REHABILITATION SERVICES, PC. PALISADES REHABILITATION SERVICES will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The patient or his/her legal guardian is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

**SECONDARY INSURANCE COVERAGE**

I understand that if I fail to disclose any secondary insurance coverage at the time of this signing or after the first service date when said insurance became effective, I can be held responsible for any balances indicated by my primary coverage. This includes balances due to lack of authorization for secondary service.

- I do not have secondary coverage to my Medicare or Auto Coverage
- I choose not to use my secondary coverage after Medicare or Auto processes the claim

**HOME HEALTHCARE**

As a Medicare Beneficiary, I am aware that I cannot receive physical or occupational therapy through an independent clinic if I am currently enrolled with a Home Healthcare Agency. If services were provided and I was not formally discharged by the agency, I realize that I will be held responsible for services denied by Medicare.

NAME OF AGENCY: \_\_\_\_\_ DATE OF DISCHARGE: \_\_\_\_\_

**CANCELLATION POLICY**

I have been advised that it is my responsibility to cancel appointments 24 hours in advance. I have been made aware that PALISADES REHABILITATION SERVICES, PC. reserves the right to bill me for appointments not cancelled with due notice.

**I HAVE READ AND UNDERSTAND ALL OF THE ABOVE, AND CERTIFY THAT I AM THE PATIENT (OR HIS/HER LEGAL GUARDIAN) PRESENTING FOR SERVICES OR AN AUTHORIZED AGENT BY THE PATIENT TO EXECUTE THIS FORM.**

**Patient Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Relationship to patient: SELF / GUARDIAN / AGENT / OTHER:** \_\_\_\_\_ **Date:** \_\_\_\_\_