TOTAL HEALTH & REHABILITATION, INC.

AUTHORIZATION AND SIGNATURE FORM

Patient Name____
Please Print

__________ **Initials**

INSURANCE ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits directly to Total Health & Rehabilitation, Inc. for any physical therapy services rendered to me or my dependent. I understand that I am responsible for all costs of treatment, regardless of insurance coverage.

__________ **Initials**

CONSENT FOR TREATMENT / CONFIDENTIALITY AGREEMENT

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.

__________ **Initials**

AUTHORIZATION AND RELEASE OF PROTECTED HEALTH INFORMATION

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.

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 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

9/12/2014 dlf