Muscle & Spine Rehabilitation Center Patient Authorization

Patient Name:	Date of Birth:

Release of Information & Consent for Treatment

Knowing that I have a condition requiring treatment and/or medical tests at Muscle & Spine Rehabilitation Center (MSRC), I am aware of my diagnosis and wish to receive treatment at this facility. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I consent to rehabilitation and and related services at this facility. I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I hereby authorize Muscle & Spine Rehabilitation Center to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize Muscle & Spine Rehabilitation Center and/or its affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal Privacy Regulations.

The signature below certifies that I have read and understand the above information and this form will expire ONE YEAR from the date it is signed, unless I notify MSRC in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. **Initial:** _____

Assignment of Benefits

I authorize payment directly to Muscle & Spine Rehabilitation Center, its subsidiaries and/or affiliates for services and to bill and release payment directly to Muscle & Spine Rehabilitation Center, its subsidiaries and/or affiliates for any physical therapy services provided.

I authorize Muscle & Spine to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. **Initial:** _____

Notice of Privacy Practices (HIPPA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Muscle & Spine Rehabilitation Center, its subsidiaries, and/or affiliates.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. **Initial:** _____

Payment Guarantee

I agree to pay Muscle & Spine Rehabilitation Center, its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allows for speedy collection from my third-party payer. I understand that I am responsible for any health insurance deductibles and co-insurances/co-pays, and that any amounts not paid by insurance are my responsibility per my contract with my insurance company. I also understand that in the event this account is placed with a collection agency or small claims court, I will be responsible for the collection fees associated with the collection of this account. **Initial:** _____

Patient Information & Authorization Sheet

I hereby acknowledge that all information provided on the Patient Intake/Registration Form and the Patient Authorization Form are true and correct.

Patient or Guardian Signature: _____ **Date:** _____