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. I also agree that I may be personally responsible for a charge of $20 per visit if I do not inform ProCare Rehabilitation LLC within 24 hours notice that I am unable to keep an appointment.

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 _________________