



Patient Authorization Form

Patient Name (please print) _____

Release of Information

All information provided herein is true and correct. I hereby consent to treatment. I give permission for Friendship Heights Rehabilitation Center, LLC 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.

I authorize Friendship Heights Rehabilitation Center, LLC. to obtain medical records and/or professional information from my physician and other medical professionals as it relates to my treatment. Information without patient identifiers may be used for quality assurance purposes.

Assignment of Benefits

I authorize payment directly to Friendship Heights Rehabilitation Center, LLC. 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.

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Friendship Heights Rehabilitation Center, LLC. 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.

Payment Guarantee

I agree to pay Friendship Heights Rehabilitation Center, LLC for the services and/or products provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services and/or products I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

I acknowledge that the benefit verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, or that coverage is insufficient, I will be responsible for payment of any unpaid portion of payment for any and all services and/or products received from Friendship Heights Rehabilitation Center, LLC.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Friendship Heights Rehabilitation Center, LLC.

I have read the above and understand the information provided. I authorize treatment and the release of information as explained. I approve of the Assignment of Benefits, acknowledge I have received the HIPPA Notice of Privacy Practices and guarantee payment.

Patient or Guardian Signature: _____

Date: _____

Attorney Signature (if applicable): _____

Date: _____