Total Rehab-Orthopedic and Sports Specialist, PC

Consent for Care and Treatment:

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, (hereinafter "Patient") hereby consent and authorize Total Rehab-Orthopedic and Sports Specialist, P.C., its agents, associates and employees, to provide care and treatment to Patient per program policy and/or as prescribed by a physician. A representative of Total Rehab-Orthopedic and Sports Specialists P.C., has explained my plan of care and all of my questions have been answered satisfactorily. I understand that the training plan may change and, if so, these changes will be discussed with me. I agree to promptly notify Total Rehab-Orthopedic and Sports Specialists, P.C., my physician or others providing care of any adverse reactions or other significant events relating to my health. Patient acknowledges that no guarantees have been made as to the effect of such examination or treatment of Patient's condition by Total Rehab-Orthopedic and Sports Specialist, P.C., its agents, associates and employees.

Authorization to Release Information:

I authorize Total Rehab-Orthopedic and Sports Specialist, P.C., its agents, associates and employees, to release any information acquired in the course of Patient's examination or treatment, to Patient's physician, health care provider or referring agency.

I authorize Total Rehab-Orthopedic and Sports Specialists, P.C., its agents, associates and employees, to disclose and release such information from Patient's medical records as may be necessary for the completion of claims filed by Total Rehab-Orthopedic and Sports Specialists, P.C., for reimbursement from my insurance company, preferred provider organization, health maintenance organization or utilization review organization.

This authorization for release of records is valid until revoked by me in writing.

Production of Confidential Information:

In order to provide Patient with the best treatment possible, Total Rehab-Orthopedic and Sports Specialist, PC must obtain certain information. This information includes confidential information such as Patient or guarantor's Social Security Number. As a patient, I understand the need for Total Rehab-Orthopedic and Sports Specialist, PC, its agents, associates and employees to obtain the most accurate information regarding my health and care. Total Rehab-Orthopedic and Sports Specialist, PC, its agents, associates and employees will protect all confidential information you provide to the best of their abilities to prevent any re-disclosure of information without authorization. If confidential information is not provided, including Social Security Numbers, Patient understands that services may only be provided by Total Rehab-Orthopedic and Sports Specialist, PC on a prepaid cash basis.

Assignment of Benefits and Liability of Payment:

In consideration of the services rendered or to be rendered by Total Rehab-Orthopedic and Sports Specialists, P.C., I assign my insurance, Medicare and Medicaid benefits due me to Total Rehab-Orthopedic and Sports Specialists, P.C. I request and authorize my insurance company and/or Medicare to make payments of authorized benefits directly to Total Rehab-Orthopedic and Sports Specialists, P.C. I understand that I am financially responsible for any unpaid balance. I further authorize the release of any information necessary to satisfy my claim.

I **understand what I have read and what was explained to me and agree to the terms and conditions stated above. I understand that either party may terminate this agreement at any time, upon written notice to the other party.**

Patient's Name (print): ___________________________

Patient's Signature: _____________________________ **Date**:______________

Parent or Guardian's Name (print): _________________________________

Parent or Guardian's Signature (if applicable):_______________________________ **Date**:___________

Total Rehab-Orthopedic and Sports Specialist, PC

FINANCIAL CONSIDERATIONS FOR SERVICE

Account Summary:

- Co-payments or co-insurance will be collected the day of service. Total Rehab accepts cash or checks.
- All other charges are due and payable within 15 days of receipt of statement.
- If payment cannot be made when due, you must contact Total Rehab at 641-236-4506 to set up a payment arrangement.
- After 90 days, if no payments have been received and extended payment arrangements have been made, necessary collection proceedings will begin.
- Total Rehab should be notified of address changes immediately since undeliverable statements are turned over to collection agencies.
- Total Rehab should be notified of any insurance changes since incorrect information will result in unpaid claims that will be your financial responsibility.

Insurance:
Total Rehab will submit claims to most insurance policies. Present your insurance card at the time of service for verification of submission. We will need to see a copy of the front and back of your insurance card. Without a card, Total Rehab cannot file for you. You will also be required to provide us with information about the insured party such as their date of birth and Social Security Number and employment information. This is information that your insurance company requires to submit your claims.

Collection of Accounts:
If your account has been sent to a collection agency, each future visit will need to be paid in full in cash at the time of service, regardless of your insurance coverage. This will be the policy until your account is back in good standing.

Bankruptcy Accounts:
If Total Rehab is served with a Bankruptcy notice, all future visits in this office will be paid in full in cash at the time of service regardless of your insurance coverage. You will no longer be able to charge any visits to your account.

Returned Check Fee:
There is a $50.00 fee for any checks that are returned to us.

Interest on Unpaid Accounts:
Interest shall accrue on any account which is past due. Interest shall accrue at the rate of 18% per annum (1.5% per month). An account is past due if it has not been paid within 60 days of the invoice or statement date.

Attorney Fees/Court Costs/Venue:
I understand that in the event that litigation is necessary to collect upon my account, venue for any such suit shall lie in Poweshiek County, Iowa, the County in which services are intended to be performed by Total Rehab-Orthopedic and Sports Specialist, PC. I further understand and agree that in the event suit is necessary to collect an unpaid account, Total Rehab-Orthopedic and Sports Specialist, PC shall be entitled to recovery of its reasonable and necessary attorney fees incurred in collecting such account, as well as the Court costs incurred.

I understand the above stated information and agree to abide by these considerations.

Signed:________________________________ **Date:** ______________