Tuscaloosa
Rehabilitation
And
Hand
Center

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for **Tuscaloosa Rehabilitation and Hand Center**, **(TRAHC)** to provide medical treatment to _____ which is considered medically necessary and proper in diagnosing and/or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party_____ Date: _____

BENEFITS AND RELEASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third-party payors to (TRAHC). A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party_____ Date: _____

FINANCIAL POLICY STATEMENT

We will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If your insurance company has an internal fee schedule which is USUAL AND CUSTOMARY, you will be responsible for the difference remaining.

If your insurance company pays you directly for services billed by TRAHC, you recognize the obligation to promptly submit the same to TRAHC.

The above may not apply for those patients that are covered by Worker's Compensation. However, please understand that if you claim Worker's Compensation benefits, but are denied such benefits, you may be held responsible for the total amount of charges for the services provided to you.

When you pay by check, you authorize TRAHC to recoup the state maximum allowed for returned or dishonored checks as well as a processing fee. You can have the state recovery fee authorization revoked by calling 1-888-235-4635, however TRAHC may attempt to collect on a returned check by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

HIPAA

TRAHC will use and disclose your personal health information to treat you, to receive payment for the care we provide, to communicate via phone or text with your physician, and for other health care operations. Health care operations may include those activities we perform to improve the quality of care. A detailed of **NOTICE OF PRIVACY PRACTICES** will be available to help you better understand our procedures for use of your personal health information. The notice may change; therefore, we will always post the most current notice in our facility and have copies available for your benefit. The undersigned acknowledges the receipt of this information.

I UNDERSTAND MY FINANCIAL RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____
Patient/Guardian/Responsible Party Date

_____ _____
Facility Representative/Witness Date