Great Northern Rehab

ORTHOPEDIC / SPORTS / HANDS / OCCUPATIONAL HEALTH

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION AND AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We feel strongly that all patients deserve the very best medical care we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy. Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.

PLEASE READ AND INTIAL THE FOLLOWING:

_____ I authorize this office to release or receive any information necessary to expedite insurance claims

_____ I hereby authorize this office to bill my insurance company directly for their services

_____ I authorize payment directly to this provider of my insurance benefits otherwise payable to me

_____ In the event I receive payment from my insurance carrier, I agree to endorse any payment over to the provider for which these fees are payable

_____ I hereby authorize Great Northern Rehab and/or occupational therapist(s) to release information regarding services rendered by them and allow a photocopy of my signature to be used to file insurance. I hereby authorize Great Northern Rehab to perform any service (evaluation, treatment procedures, and testing) necessary for my rehabilitation

_____ Great Northern Rehab is granted permission to release to the insurance carrier, employer, attorney, their representatives, or referring physician, any information in connection with any treatment rendered to patient or on patient's behalf at any time such information is requested.

_____ **HIPAA** – I have received the Practice's "Notice of Privacy Practices" and understand that my protected health information may be used by the Practice as described in the notice.

I understand that I am directly and completely responsible to this provider for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I eventually recover said fee.

A Photostat copy of these authorizations and agreements shall be as valid as the original.

_____ _____ _____

Patient or Guardian (print) Patient or Guardian (signature) Date