CONSENT FOR CARE AND TREATMENT

I, THE UNDERSIGNED, DO HEREBY AGREE AND GIVE MY CONSENT TO ARROW REHABILITATION TO FURNISH MEDICAL CARE AND TREATMENT TO: ________________________________ CONSIDERED NECESSARY AND PROPER IN DIAGNOSING OR TREATING THEIR PHYSICAL CONDITION.

PATIENT/GUARDIAN: ___________________________ DATE: ____________

BENEFIT ASSIGNMENT OF INFORMATION

I, HEREBY, ASSIGN ALL MEDICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITILED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLAN TO ARROW REHABILITATION. A PHOTOCOPY OF THIS AGREEMENT 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: ___________________________ DATE: ____________

FINANCIAL POLICY

REGARDING INSURANCE:
IF YOU HAVE AN INSURANCE THAT REQUIRES A CO-PAY, THIS CO-PAY IS DUE AT THE TIME OF SERVICE. WE WILL FILE YOUR INSURANCE AS A COURTESY TO YOU. IF YOU DO NOT HAVE INSURANCE, FULL PAYMENT IS DUE AT TIME OF SERVICE. WE RESERVE THE RIGHT TO ADD INTEREST AT 12% PER ANNUM ON ANY BALANCE THAT IS OVER 120 DAYS PAST DUE.

I HAVE READ THE FINANCIAL POLICY AND I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

IF YOU FAIL TO KEEP YOUR APPOINTMENT AND DO NOT CALL THE OFFICE WITH A 24 HOUR NOTICE, YOU MAY BE CHARGED $35.00.

____ DATE: ______________
Signature of Patient or Responsible Party

Initiated: 3/25/04
Revised: 9/10/08