RehabHealth
Leaders in Rehabilitation Medicine

Patient Authorization to Release Medical Information

PATIENT'S NAME: _____

DATE OF BIRTH: _____ **AGE:** _____

I authorize the release of personal medical, psychiatric, drug and/or alcohol abuse information and records to or from RehabHealth PC, 1320 West Main Street, Waterbury, CT 06708. It is my understanding that this information is to be used for the purposes of diagnosis, treatment, communication with referring physicians, and to complete insurance claims. A photocopy of this release is as valid as the original.

Patient Initials: _____

Authorization of Payment of Medical Benefits

I authorize payment of medical benefits to RehabHealth PC for services provided by their employees. A photocopy of this release is as valid as the original.

Patient Initials: _____

The confidentiality of this record is required under the Connecticut General Statues. This information shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statues.

RehabHealth Payment Policy

I understand that any bills that I incur at RehabHealth are ultimately my responsibility. If my workers' compensation carrier denies my claim, if my motor vehicle accident insurance becomes exhausted, or if my medical insurance term runs out during my treatment here, I will take responsibility for all payment of any outstanding bills. If my balance remains unpaid after 60 days, I understand that an interest charge of 1.5% per month will be added to my balance. If my account is turned over to a collection agency, I will pay for all collection fees and court costs.

If my insurance is part of any HMO or managed care organization, I understand that I will be responsible for making payments for any treatment I receive from a physician/provider at this office that may not be affiliated with my plan. I understand that my insurance plan may have a referral or authorization process that must be followed in order for services to be paid. I understand that I am responsible for payment of any care I receive beyond which is authorized, and for any care that is not a covered benefit under the terms of my plan.

Patient Initials: _____

RehabHealth "No Show" Policy

I agree that if I am unable to attend my appointed M.D. follow-up or physical therapy appointment, I will:

- Call to cancel before the appointment.
- Reschedule for the earliest possible date.

If I do not make such calls, I understand that I will be noted as a "No Show" for that appointment. I understand that after three (3) "No Shows", RehabHealth reserves the right to charge a $45 "No Show" fee. Accumulation of three (3) such "No Show" notations will result in:

- Termination of treatment (discharge).
- Notification of my referring physician.

I understand that this policy has been established for my benefit because:
Continuity of treatment is important for successful and rapid rehabilitation.
Rescheduling upon cancellation assures that I get the time and day more convenient for me.
I further understand that this policy does not denote refusal of treatment.

Patient Initials: _____

I agree to all of the above:

SIGNATURE: _____ **DATE:** _____

Responsible Party (if minor): _____ **DATE:** _____

Witness: _____ **DATE:** _____