Patient Name:

Total Body Rehab

PATIENT INTAKE AND CONSENT FORM

CONSENT TO TREATMENT

I consent to rehabilitation and related services at:
Total Body Rehab
In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:** ___________

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. **Initials:** ___________

LIABILITY

I know and agree that: Total Body Rehab
is not responsible for loss or damage to personal valuables. **Initials:** ___________

WAIVER AND RELEASE

I hereby release, discharge and acquit: Total Body Rehab
its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. **Initials:** ___________

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: Total Body Rehab
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. **Initials:** ___________

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf.

Initials: ___________

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials:** ___________
I acknowledge receipt of the Statement of Patient Rights. **Initials:** ___________

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature __________________________ **Witness Signature** __________________________ **Date** _____________