

Chicago Rehabilitation Services, Inc.
Privately Owned and Independent Physical Therapy Center

CONSENT / AUTHORIZATION FORM

CONSENT FOR TREATMENT I authorize Chicago Rehabilitation Services to perform the treatment/procedures described below. I will be informed of the reasons for the treatment/procedure(s), along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved in the following:

Physical Therapy Evaluation and Treatment Per M.D. script.

The treatment/procedure(s) will be explained to me in detail and all my questions will be fully answered. Understanding this, I authorize Chicago Rehabilitation Services to perform such evaluations, treatment and Iontophoresis (as ordered by my physician).

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

RELEASE OF MEDICAL RECORD In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or provider, if any, who referred me here.

INSURANCE AUTHORIZATION I request that payment of authorized benefits be made to the above named doctor(s) on my behalf, for any services provided to me. I authorize any holder of medical and other third party Payor, state medical assistance agency, or any other governmental or party payer responsible for paying such benefits, any-information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in the place of the original.

Signed: _____ Date: _____

Consent for Medical Financial Limitations for Physical Therapy for Patient active with Home Health Care

I, _____, hereby give my consent to Chicago Rehabilitation Services that it is to my understanding that I am responsible for notifying Chicago Rehabilitation Services of any Home Health Care services that I am or have received recently. These Home Care Services would interfere with Medicare part B Payment for Out Patient Physical Therapy and I am financially responsible for that if I falsify this information.

I also consent that I was made aware of the Medicare regulations that control payments for out-patient physical therapy for these patients who receive Home Health Care services (consolidated billing). A copy of these regulations was shown to me.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____ .