REHAB PARTNERS, INC.

AUTHORIZATION FOR:
AUTHORIZATION FOR TREATMENT - ASSIGNMENT OF MEDICAL BENEFITS AND PAYMENT RESPONSIBILITY PT OT LMT

Patient's Name: _____
FACILITY / PROVIDER : REHAB PARTNERS, INC.

1.) **THE UNDERSIGNED**, hereby authorizes therapy at **REHAB PARTNERS, INC**. to render to patient Physical Therapy, Occupational Therapy, Massage Therapy or other related services (collectively, "Therapy Services") that provider or patient's treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with the Provider's rendition of therapy services.
2.) **THE UNDERSIGNED**, hereby certifies that all information provided to the Provider by the undersigned or patient including any information in connection for applying for payment under title XVIII of the Social Security Act is true, correct and accurate in all respects.
3.) **THE UNDERSIGNED**, hereby authorize Provider to disclose any information furnished to the Provider or obtained by Provider in connection with the patient's treatment (including information concerning a related Medicare claim) to any physician, governmental agency (including the Social Security Administrations or any of its intermediaries or carriers) insurance company or health care facility requesting such information.
4.) **THE UNDERSIGNED**, hereby assign to Provider all Medicare benefits to which the patient may be entitled for any therapy services rendered by the Provider. The undersigned hereby authorize and direct the Provider to apply and file for all such benefits on behalf of the patient in the event the patient is covered by both Medicare and Medicaid. The undersigned acknowledge that the Provider has disclosed to the undersigned that the Provider is a supplemental Medicaid Provider and the Provider is paid directly by Medicaid. In addition, the undersigned approves contact with the appropriate family members for medical or claims management purposes.
5.) **THE UNDERSIGNED**, hereby assign to the Provider all Private Medical Insurance benefits (primary and secondary, including med gap providers) or other benefits to which the patient may be entitled for any therapy services rendered by Provider. The undersigned hereby authorize and direct Provider to apply and file for all such benefits on behalf of the patient.
6.) **THE UNDERSIGNED**, agree that the undersigned shall be jointly and severally financially responsible for any portion of the Providers invoice that is not paid, except in the case of a Medicare denial or Medicaid eligible recipients. The undersigned warrant and represent to the Provider if member is a Medicare participant that patient is not a member of or covered by a Health Maintenance Organization or similar arrangement as their primary insurance coverage. The undersigned shall be liable to Provider for all services rendered by Provider in the event the patient is covered by a Health Maintenance Organization or similar arrangement.
7.) **THE UNDERSIGNED**, and patient if applicable agree to execute any documents and perform any acts that the Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any Powers of Attorney, Health Care Surrogate or Court Orders appointing the undersigned as the legal guardian of the patient.
8.) **THE UNDERSIGNED**, agree that the provisions hereof shall continue in full force and effect until Provider received written notice of termination by the undersigned: provided however that the provisions in paragraphs 1,2,3,4,5,6, and 7 shall survive any such termination.

WITNESSES:

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_____

X _____
PATIENT SIGNATURE / LEGAL REPRESENTATIVE

DATE:_____

_____
FINANCIALLY RESPONSIBLE PARTY IF NOT PATIENT

DATE: _____