MICHIGAN ABILITIES CENTER

PHYSICAL MEDICINE AND REHABILITATION

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Consent for Treatment and Payment Agreement

I hereby authorize Michigan Abilities Center Physical Medicine and Rehabilitation to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatment, the administration of any needed anesthetics, the use of prescribed medications, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to Michigan Abilities Center Physical Medicine and Rehabilitation of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized payers, auto accident insurers, or for work-related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer network.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for paying your copay and/or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Michigan Abilities Center Physical Medicine and Rehabilitation all insurance or third-party payment that I receive for services rendered to me immediately upon receipt.

Signature:_____ **Date:**_____

Signature of Client / Responsible Party (guardian or parent if under 18 years old)