Columbia Rehabilitation Clinic
Patient Information & Consent Form

I have read and fully understand the Columbia Rehabilitation Clinic (CRC) Notice of Information Practices and I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits, (2) attorney and (3) any physician involved in my medical care. I realize the authorization allows CRC to release any information to any of my insurers or physicians for the purposes of carrying out treatment.

I authorize and direct my insurers/attorney to pay directly to CRC any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign CRC any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive.

I understand that I am financially responsible to CRC for all charges not covered, approved or considered necessary by my insurance company. I will pay at the time of service or have an agreeable payment arrangement set up with the business office.

I understand that there will be a $35.00 charge for any un-cancelled appointments (no show). Please make sure that you cancel any appointments that you are unable to attend **prior** to the scheduled appointment time (preferably 24 hours).

Signature: _____Date: _____

Signature: _____ Date: _____
Responsible Party Signature (if different)

Consent to Treatment for Physical Therapy

I hereby give permission for Columbia Rehabilitation to provide Physical Therapy to:

Printed Name: _____ **Date:** _____

Signature: _____ **Date:** _____