SPOT Rehabilitation Inc.
Speech Physical Occupational Therapy

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CONSENT FOR THERAPY EVALUATION AND TREATMENT

I, the undersigned, have been informed of the need for speech, physical and/or occupational therapy, including the nature, goals, methods, and expected outcome of such treatment, authorize and consent to services for _____, as ordered by the attending physician.

In addition, I authorize the exchange of records and any such information regarding treatment as is necessary to my physician, Medicare, Medical Assistance, or any other insurance carriers for the purpose of obtaining insurance or other third party reimbursement.

SPOT Rehabilitation provides service to all persons regardless of race, color, national origin, religious or fraternal organization, disability status, HIV status, gender or age.

HEALTH PLANS ARE A CONTRACT BETWEEN MY INSURANCE AND ME. MY HEALTH CARE PROVIDER, INSURER, OR HEALTH PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION AND I MAY BE OBLIGATED FOR PAYMENT OF DEDUCTIBLES, COPAYS AND/OR PARTIAL OR FULL PAYMENT FOR THERAPY SERVICES RENDERED. I UNDERSTAND THAT PRIOR AUTHORIZATION AND CLAIM SUBMISSION BY SPOT REHABILITATION IS A COURTESY TO ME. IF MY HEALTH PLAN FAILS TO PAY WITHIN 30 DAYS, I AGREE TO PAY FOR SERVICES WITHIN 30 DAYS OF BILLING.

_____ _____
Patient or Patient Representative Date

In the event of necessary schedule change or other communication, please contact:

_____ _____
Representative of SPOT Rehabilitation Telephone Number

White–Main Office Chart Yellow–Billing Pink–Patient/Client