SPOT Rehabilitation Medical Issues, Insurance Changes

And Medical Treatment Authorization

Insurance changes:

Please inform the front office staff of any changes in your insurance immediately. You are ultimately responsible for payment of any services provided which are not covered by insurance OR services provided without insurance coverage.

Medical issues:

If your child has significant medical issues, we may ask that you remain in the building during their therapy sessions. Please see our medical release.

Medical Treatment Authorization:

This form grants temporary authority to SPOT Rehabilitation to provide and arrange for medical care for a patient/minor in the event of an emergency, where the patient/minor is not accompanied by either parents or legal guardians, or spouses and it may not be possible to contact them. This form should be carried by the SPOT Rehabilitation employee/representative.

AUTHORIZATION AND CONSENT OF PATIENTS/PARENT(S) OR LEGAL GUARDIAN(S)

I grant my authorization and consent for **SPOT REHABILITATION, INC**. to administer general first aid treatment for any minor injuries or illnesses experienced by the Patient/Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize SPOT Rehabilitation, Inc. to summon any and all professional emergency personnel to attend, transport and treat the patient/minor and to issue consent for any treatment or hospital care deemed advisable by and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state of Minnesota. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of SPOT Rehabilitation, Inc. in the exercise of their best judgment upon the advice of any such medical or emergency personnel.

I have read and understand the Insurance Changes, Medical Issues and Medical Treatment Authorization Policies for SPOT Rehabilitation and I agree to comply with these policies:

Name of Patient: _____

Patient/Parent/Legal Guardian

Signature: _____

Printed Name: _____

Date: _____