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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, sex 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, CO-PAYS 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.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years or older**, the patient must sign and date form.
- **If the patient is 18 years or older and is incapable of signing**, a legally authorized substitute may sign and date the form. Please indicate your legal authority and **include documentation of your relationship**:

Legal Guardian or Conservator Health Care Agent (Health Care Power of Attorney)

- **If the patient is 17 years of age or younger**, the patient's parents or legal guardian must sign and date the form, unless an exception exists under federal law. Please indicate your relationship:

Parent Legal Guardian

Signature (Required):

Date Signed (Required)(Month,DD,YYY):

Printed Name of Person Signing (If Not Patient):