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## Consent Form

Patient Name \_\_\_\_\_ Outpatient # \_\_\_\_\_

### CONSENT FOR EXAMINATION AND TREATMENT:

I hereby give permission for treatment and/or any laboratory, x-ray, inhalation and/or rehabilitation therapy, etc. that the attending physician has ordered. Residents, students or other medical personnel may participate in my treatment as deemed appropriate by the attending physician.

### AUTHORIZATION TO PAY INSURANCE BENEFITS:

I hereby authorize payment directly to the above named hospital upon receipt of the itemized statement for services rendered to the patient, benefits herein specified and otherwise payable to the undersigned, but not to exceed hospital's regular charge for this service.

### GUARANTY OF ACCOUNT:

In consideration of services rendered or to be rendered by St. Lawrence Rehabilitation to the named patient, we (I) jointly and separately guaranty payment of any and all services rendered which are not covered or allowed by any insurance coverage. We (I) understand all bills are payable and become due upon receipt. We (I) understand that all accounts not settled will be forwarded to a collection agency.

### AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the above named hospital to release any necessary information related to my financial records and medical records, within 90 days.

### RECEIPT OF OUTPATIENT HANDBOOK:

I acknowledge that I have received and will be responsible for reviewing the outpatient handbook, which contains information about outpatient services, programs, policies, and patient rights and responsibilities.

### BENEFIT INFORMATION:

I acknowledge that my insurance coverage has been adequately explained to me. I agree to **immediately** notify the Outpatient Coordinator of any change in my health insurance coverage or identification number.

Patient / Guarantor \_\_\_\_\_ Date \_\_\_\_\_

OP Staff / Title \_\_\_\_\_ Date \_\_\_\_\_