CAROLINA ORTHOPEDIC REHAB, LLC
CONSENT FOR TREATMENT

PATIENT NAME____ D.O.B________________

By signing this Consent for Treatment, I hereby authorize Carolina Orthopedic Rehab, LLC and the healthcare providers therein consent to: **(please initial each item)**

____Perform assessment and treatment deemed medically necessary for me or the above named patient.

____ Disclose any information to outside providers and/or agencies involved in my treatment as deemed medically necessary or permitted by law. Release any information required in the course of my assessments and treatments for the purpose of insurance and/or Medicare Benefits payment.

____ Assign payment directly to Carolina Orthopedic Rehab, LLC of all medical benefits applicable and otherwise payable to me or the above named patient through insurance or any other source. I understand and agree that if I receive payment from my insurance company or any other source I must submit this payment to Carolina Orthopedic Rehab, LLC in a timely manner.

PAYMENT POLICY

____Carolina Orthopedic Rehab, LLC will bill your insurance as a courtesy to you. To do so, **you are required** to present to Carolina Orthopedic Rehab, LLC up to date insurance card. **It is your /the above named patient's responsibility to know and understand your healthcare benefits**.

____**Co-pays, deductibles and co-insurance amounts are due at time of service**.
Payment arrangements for any unpaid balance(s) must be made prior to end of care. Any unpaid balances must be satisfied within 60 days, after which time an interest rate of 1.5% of the unpaid balance or the highest percentage legally allowed may be imposed. **Carolina Orthopedic Rehab, LLC reserves the right to submit your information to a collection agency and/or credit bureau which will create a blemish on your credit.**

____ I agree in consideration of the services rendered to me that I am hereby individually obligated to pay my account with Carolina Orthopedic Rehab, LLC in accordance with its regular rates and terms.
If signing as a patient representative, a parent or a guardian, or otherwise legally responsible person for the patient, I agree to the obligation described herein.

________________________________ ________________________ ____________________
Signature of Patient/Responsible Party Relationship to Patient Date

_________________________________ ______________________
Signature of Witness (Carolina Orthopedic Rehab Representative) Date