MAJOR CHANGES
Rehab Centre
www.majorchangesrehab.com

MAJOR HAÜS
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CONSENT FORM

Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to the provider and any assisting providers for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees, if required. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Insurance authorization must be obtained before a patient is seen. If I do not inform the providers in this facility of my current insurance and the insurance is denied because of no authorization, I will be responsible for payment. If authorization is not obtained from the insurance company before my scheduled appointment and I still choose to be seen by the provider, I will be responsible for the bill at the time of service.

Privacy Notice

I hereby acknowledge that I have received a copy this facility's Privacy Notice. I further acknowledge that a copy of the current Privacy Notice is displayed in the reception area. Upon request, I will be offered a copy of any amended Privacy Notices.

PATIENT NAME:	
SIGNATURE:	
DATE:	
RELATIONSHIP:	

If unsigned by the patient, please indicate the relationship between the signee and the patient.

Consent for a Minor

I grant the providers associated with this facility the authority to administer treatments and perform such procedures as are deemed necessary for this patient.

PATIENT NAME:	
SIGNATURE:	
DATE:	
RELATIONSHIP:	

For Office Use Only

Date Received:
Copayment:
Authorization – Yes [ ] No [ ]
Processed By: Auth#:
Practice Follow-up – Yes [ ] No [ ]
Date of Follow-Up: