**Please return**


# CONSENT FORM

**Consent for Treatment:**
I request and authorize the staff of Coastal Rehab, LLC to provide therapy services as outlined in the therapy evaluation and plan of care. I understand that all services are medically indicated and conducted under the orders of my physician. I agree to notify the therapist of any changes in my medical condition.

**Assignment of Benefits:**
I request that payment of authorized insurance benefits be made directly to Coastal Rehab, LLC for any services furnished to me. I authorize any medical information pertaining to these services be released to my insurance company to determine these benefits or the benefits payable for related services.

**Financial Responsibility:**
I understand that I will be responsible for any charges not covered by third party payers and agree to pay any deductibles, co-payments, etc. that may not be covered in a timely manner. I understand that Coastal Rehab, LLC will be billing my insurance company/companies and that in the event an item is not covered, I will receive a written explanation from Coastal Rehab. **I understand that it is my responsibility to update Coastal Rehab on any changes in my insurance. I will notify Coastal Rehab, LLC immediately if home health services are initiated, as this will result in a denial in payment.**

*Medicare Part B only: Medicare covers 80% of the allowable charges.

**Statement of Privacy/Confidentiality:**
I understand that Coastal Rehab will respect the privacy and confidentiality of all health information disclosed as required by law. I have been provided with the Notice of Privacy Practice.

**Transfer of Medical Information/Release of Information:**
I authorize and understand that it may become necessary to disclose/transmit information regarding my medical condition to other agencies or individuals outside of Coastal Rehab. You may revoke this authorization at any time in writing. You may also limit this authorization now or at any time in writing:

_____ _____
Patient's Name (printed) Patient's Date of Birth

_____ _____
Patient's Signature (or POA's/Representative's) Relationship to Patient

_____
Today's Date

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