Central Nebraska Rehabilitation Services, LLC
Registration Consent Form

Label

AUTHORIZATION of Assignment of Benefits/Insurance Appeals:

I hereby give authorization for payment of insurance benefits to be made directly to Central Nebraska Rehabilitation Services, LLC, for services rendered here. I understand that I am financially responsible for all charges whether or not they are covered by insurance.
I authorize any information pertaining to any medical claim, grievance, or appeal, including any external review rights, filed by Central Nebraska Rehabilitation Services, LLC on my behalf be released or received by Central Nebraska Rehabilitation Services, LLC. I authorize Central Nebraska Rehabilitation Services, LLC to act as my Authorized Representative regarding claims, grievances and appeals for services rendered by Central Nebraska Rehabilitation Services, LLC for as long as I, or the patient, is treated at, or have outstanding claims with, Central Nebraska Rehabilitation Services, LLC.

Patient Signature: _____ Date: _____
(Signature of Patient, Parent, or Guardian)

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Power of Attorney

VISIT LIMITS and SUPPLIES:

I understand that my insurance company may have a calendar year limit as to how many therapy visits, they will allow, and this may also include any chiropractor visits or osteopathic physiotherapy visits. Although as a courtesy Central Nebraska Rehabilitation Services, LLC, will track the visits I have here, they are unable to track any treatment outside their facility. I may be responsible for any visits that go over my covered limit. I understand that if my health insurance carrier does not cover a supply, I am responsible for payment in full for the supply. **Initial:** _____

Photo Release:

I hereby grant Central Nebraska Rehabilitation Services and its entities permission to the rights of photographs and/or video recordings of me without payment or any other consideration. I understand that my image or video may be edited, copied, exhibited, published, or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed in any format and for any purpose. I hereby hold harmless, release, and forever discharge CNRS from any and all claims, demands, and causes of action without limitation which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization. By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material. I also hereby agree to allow CNRS the use of comments made within patient records systems for publicity and marketing purposes.

Signed _____ Date _____ I Decline _____ (initial)

If individual photographed/recorded is under nineteen (19) years old, the following section must be completed: I have read, and I understand this document. I understand and agree that it is binding on me, my child (named above), our heirs, assigns and personal representatives. I acknowledge that I am nineteen (19) years old or more and that I am the parent or guardian of the child named above.

Signature of Patient or Responsible Party _____ Relationship to Patient_____ Date_____

FINANCIAL AGREEMENT

In the event of default, I agree to pay all costs of collections, and reasonable attorney fees. I hereby authorize Central Nebraska Rehabilitation Services, LLC, to release all information to insurance companies, attorney, or other physicians to secure the payment of benefits; and agree that a photocopy of this form shall be valid as the original. I understand the minimum monthly payment requirement on any balances due is 5% of the total balance or $50, whichever is greater, and that my balance must be paid in full within 6 months. If I am unable to pay in full within 6 months, approval is guaranteed through the Union Bank and Trust patient financing program. (Inquire for details.)

HIPAA PRIVACY NOTICE:

The signature below acknowledges I was offered a copy of Central Nebraska Rehabilitation Services LLC notice of privacy practices.

Permission to release medical information to:_____(optional)

CONSENT OF MEDICAL TREATMENT:

Knowing that I have (or the patient listed above has) a condition requiring diagnosis and medical treatment, do hereby voluntarily consent to such diagnostic procedures and to such medical treatment rendered by Central Nebraska Rehabilitation Services, LLC.

Patient Signature: _____ (Signature of Patient, Parent, or Guardian) Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Power of Attorney	Date