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:**_____

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. I further agree that a photocopy of this agreement shall be valid as the original. I understand that a 1% finance charge will be imposed on each item of my account, which has not been paid within ninety (90) days from my last date of service at Central Nebraska Rehabilitation Services, LLC. I understand that this finance charge will be computed by applying the periodic rate (1%) per month or an ANNUAL PERCENTAGE RATE of twelve percent (12%). This is applied to the "overdue balance" of my account. The "overdue balance" of my account is calculated by taking the balance owed ninety (90) days after last date of service, and then subtracting any payments or credits applied to my account during this time. I also understand that there is a $25.00 charge on all checks that are returned from the bank.

I also understand the minimum monthly payment requirement on any balances due is 5% of the total balance or $50, whichever is greater. I also understand my balance must be paid off within 12 months.

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: _____ Date

(Signature of Patient, Parent, or Guardian)

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