QUALITY THERAPY SERVICES, INC.

PATIENT NAME_____

DOB_____

_____

CONSENT FOR SERVICE: I authorize Quality Therapy Services, Inc. to provide rehab services to the patient named above. I understand that I have the right to refuse treatment or discontinue services at any time. I also understand that Quality Therapy Services, Inc. can terminate services by notifying me. I understand I have the right to choose my provider.

Release of medical records: I consent and request that any of my needed medical records or information be given to Quality Therapy Services, Inc. in the form of verbal communication or written copies. I understand this will be needed to develop my plan of care. I authorize Quality Therapy Services, Inc. to release copies of my medical records, or information related to my rehab care, to other health care providers or organizations to facilitate my care and claim processing. I understand that I have the right for my medical information to remain confidential and communicated only to those who have a medical need to know.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Quality Therapy Services, Inc's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. I have been presented a copy of Quality Therapy Services, Inc.'s Notice of Information Practices.

Authorization for emergency medical services: I authorize Quality Therapy Services, Inc. to provide or obtain emergency medical treatment as deemed necessary in emergency circumstances which may occur while receiving services . I agree to assume sole responsibility for all charges for this treatment.

Advanced Directives:

I do_____ Do not_____ have a living will.
I do_____ Do not _____ have a durable power of attorney

Patient rights and responsibilities: I understand my patient rights and responsibilities.

Insurance payment authorization: I request that payment of insurance benefits to be made on my behalf to Quality Therapy Services, Inc. for any services furnished to me. I authorize any holder of medical information about me to release to any payer including the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I realize that if I meet Medicare homebound criteria, I have the option to receive care under Medicare A, but instead choose to have rehab services by Quality Therapy Services, Inc. under Medicare part B, which may be subject to a co-payment or billing of my supplemental insurance policy.

I have read and understand the content of this entire consent form and agree to and authorize provisions as previously outlined.

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patient signature date

_____ _____
patient representative / relationship to patient date