CONSENT FOR CARE AND TREATMENT

I, the undersigned, hereby give my consent for Cascade Hand & Orthopedic Rehab, Inc. to furnish medical care and treatment that is considered necessary and proper in diagnosing her/his physical condition.

Patient Name: _____

Date: _____

Patient/Guardian Signature: _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all physical therapy benefits to which I am entitled, including Medicare, Medicaid, private insurance and third-party payers to Cascade Hand & Orthopedic Rehab, Inc. A photocopy of this assignment is to be considered as valid as the original. I authorize Cascade Hand & Orthopedic Rehab, Inc. to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian Signature: _____ **Date:** _____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as courtesy to you. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same amount to Cascade Hand & Orthopedic Rehab, Inc.

The above does not apply to those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of chargers for services rendered to you.

When you pay by check you expressly authorize Cascade Hand & Orthopedic Rehab, Inc. to electronically debit your account for the amount of the check. If your check is dishonored for any reason you will be charged the amount of the check plus a processing fee up to the state maximum legal limit. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235- 4635 to revoke the authorization for the electronic transaction. This does not, however mean that Cascade Hand & Orthopedic Rehab, Inc. cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fess and attorney fees.

I have read the above information and agree to pay Cascade Hand & Orthopedic Rehab, Inc. for any and all balances not covered by insurance.

Patient/Guardian/Responsible Party Signature: _____

Clinic Representative/Witness Signature: _____

Cascade Hand & Orthopedic Rehab, Inc. Responsibilities

We are required by law to maintain the privacy of your Protected Health Information, to comply with the privacy policies outlined in this notice, and to provide you this notice of privacy practices. Cascade Hand & Orthopedic Rehab, Inc. is permitted by law to reserve the right to amend or modify our privacy policies, our practices, and this document. You may review or receive copies of your PHI by submitting a written request. Cascade Hand & Orthopedic Rehab, Inc. requires that request to review your PHI, receive copies of your PHI, or request to restrict disclosures of your PHI, be submitting in writing.

Patient Signature: _____

Email Address:_____

Date of Birth (mm/dd/yyyy): _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a written copy of the Cascade Hand & Orthopedic Rehab, Inc. Notice of Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be a part of my record until such time as I may choose to revoke this acknowledgement. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

Patient/Authorized Agent Signature: _____

Date: _____

CONSENT FOR SMS CONTACT

I hereby give my consent for Cascade Hand & Orthopedic Rehab, Inc. to contact me via SMS text message to convey scheduling or other related messages.

Patient/Guardian Signature: _____ **Date:** _____