MIDSOUTH ORTHOPAEDIC REHABILITATION, LLC

Patient Registration and Consent for Medical Treatment

Consent for Health Care Services: I authorize consent for medical treatment at *Midsouth Orthopaedic Rehabililtation.*

Authorization for Release of Information: *Midsouth Orthopaedic Rehabilitation*, may release information from my medical records to any health care provider involved in my care and treatment*. Midsouth Orthopaedic Rehabilitation* may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, *Midsouth Orthopaedic Rehabilitation*, is no longer responsible for the confidentiality of any information known or possessed by the payer.

Financial Agreement: I understand I am responsible for the payment and/copayment that is due at the time of service. I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by *Midsouth Orthopaedic Rehabilitation*, which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. I agree to pay all reasonable legal expenses including, but not limited to, reasonable attorney's fees, court costs, and filing and service fees necessary for collection of any unpaid balance.
I understand that any credit or refund that I may be owed will be forwarded to the address on file with *Midsouth Orthopaedic Rehabilitation*. I understand that I am responsible for a $30.00 returned check fee in addition to any other associated bank charges.

Charge for No Show/Cancellation without 24 hour notice: I understand that 24 hours notice is required for rescheduling/ cancelling an appointment. I will be charged a $25.00 fee if I do not cancel 24 hours prior to the scheduled appointment. I understand that I will be charged $50.00 for any missed/"NO SHOW" appointment. I also understand that I will be responsible for this charge and that my insurance company will not pay for cancellation/no show fees.

I acknowledge that I have been offered and received a copy of the Notice of Privacy Practices
I acknowledge that I have read this form and understand it contents.

Signature of Patient or Legally Responsible Person

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Print Name

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Date

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