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. If a credit card is on file, we reserve the right to charge your card for services rendered. We will always contact you before we charge your credit card. It is your responsibility to respond to our attempts to contact you regarding payment. By not responding you consent to your credit card being charged for payment of services rendered.** 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 its contents.

Signature of Patient or Legally Responsible Person

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Print Name

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Date

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