CONSENT FOR TREATMENT, PAYMENT, AND ACKNOWLEDGEMENT

Patient Name:_____ Date of Birth: _____
(Print Name)

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

All information provided herein is true and correct. I am aware of, understand and have had an opportunity to ask questions to my provider regarding my diagnosis and wish to receive treatment at Lifeline Therapy. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include evaluation, testing, treatment, and education. No guarantees have been made to me about the outcome of any care. I acknowledge that this care is not a substitute for treatment or medical care of a primary care physician. I further acknowledge that I have notified Lifeline Therapy of any limitations placed on me by my primary care physician or any other treating physician and will continue to so notify Lifeline Therapy as my medical needs or limitations change.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER AND PATIENT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Administration or its intermediaries or carriers for this or a related medical claim is correct. I authorize the release of all necessary information to agencies just named as well as any Peer Review Organization. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician or clinic services to Lifeline Therapy and authorize Lifeline Therapy to submit a claim to Medicare for payment.

STATEMENT TO PERMIT PAYMENT OF MEDICAID BENEFITS TO PROVIDER

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Department of Public Welfare (D.P.W) or its intermediaries or carriers any information needed for this or a related medical claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician or clinic services to Lifeline Therapy and authorize Lifeline Therapy to submit a claim to D.P.W. for payment.

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION / FINANCIAL RESPONSIBILITY

I authorize my insurer to pay benefits directly to Lifeline Therapy. I authorize Lifeline Therapy to release all information necessary to secure payment including without limitation documentation on the medical record which may include present or past history of mental illness, alcohol abuse, drug abuse, or HIV/AIDS related information. I recognize that I am primarily liable for payment for services rendered. In the event that I am entitled to medical care benefits or insurance of any type whatsoever, I hereby assign those benefits and my rights to insurance payment to Lifeline Therapy to apply for benefits and insurance on my behalf for services rendered to me. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for prompt collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account

balances. I certify that the insurance or other coverage benefit information supplied by me is correct, in accordance with provider or insurance policies or agreements. This is a direct assignment of my rights and benefits under this policy. I further understand that this agreement is binding regardless of any legal proceeding currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Lifeline Therapy.

CONSENT TO APPEAL

In the event that my insurance company denies payment for my service, I authorize Lifeline Therapy to appeal for payment on my behalf.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy, read, or received a copy of the LifeLine Therapy Notice of Protected Health Information Practices ("Privacy Notice"); and I may obtain a copy of the Privacy Notice at any Lifeline Therapy office. I hereby consent to the use and disclosure of my personal health information for the purpose of treatment, billing to obtain payment, and health care operations as set forth in the Notice or as authorized by me in writing. I authorize Lifeline Therapy to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

BILL OF RIGHTS ACKNOWLEDGEMENT

A CORF provider may not require a person to surrender these rights as a condition of receiving services. A guardian or conservator or, when there is not guardian or conservator, a designated person may seek to enforce these rights. A provider must protect and promote these rights.
As your rehabilitation provider, we strive to provide quality services. If you need assistance have questions, or have a complaint, please contact us at any of our offices.

If you have a complaint about the facility or person providing your services, you may call, write or visit the Office of Health Facility Complaints, State Department of Health at: Office of Health Facility Complaints, State Department of Health, Health and Welfare Building, 7th & Foster Street, Harrisburg, PA 17120. Telephone number is: 651-201-4201 or 1-800-369-7994.

I have been offered a copy, read, or received Lifeline Therapy's Bill of Rights; and I may obtain a copy of the Bill of Rights at any Lifeline Therapy office.

I CERTIFY THAT I HAVE READ THIS FORM AND THAT I UNDERSTAND ITS CONTENTS.

X _____ _____

☐Patient ☐Substitute Decision Maker Witness

_____ _____

If Substitute Decision Maker State Relationship and Reason Date/Time