JIM WAMPLER

rehab

Hands-on care that makes a difference in your life.

CONSENT FOR TREATMENT
RELEASE OF INFORMATION AND PAYMENT POLICY

Patient Name _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand I have the right to be provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand my rights as described in that document.

I consent to treatment necessary for the medical care of the above-named patient. I authorize the release of any or all medical records to the referring or family physician(s), to any healthcare provider the above-named patient may be referred to, and to the insurance company or third party payor indicated above or noted in the patient's chart, if applicable. I understand that, unless I/patient specifically state otherwise, this may include information relating to HIV testing, substance abuse and psychological disorders that may be included in the medical records. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand this authorization may be revoked in writing by me/patient at any time, except to the extent that action has been taken in reliance on this authorization. Unless revoked, I confirm that this authorization will be in effect as long as the patient is under care at **Jim Wampler Rehab**, unless I/patient indicate otherwise. Fax transmittal of medical records is allowed, if indicated.

I further understand that payment on charges incurred is due at time of service unless other financial arrangements have been made with our business office prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment. I authorize and request that insurance payments be made directly to **Jim Wampler Rehab**, should they elect to receive such payment.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND AUTHORIZATION FOR TREATMENT, FINANCIAL RESPONSIBILITY, RELEASE OF MEDICAL INFORMATION AND INSURANCE PAYMENTS.

(Sign Here) _____ _____
Signature/Relationship to patient Date

220 Reservoir Street ● Harrisonburg, VA 22801 ● Phone: (540) 434-9267 ● Fax: (540) 434-2404