All Information on this Form is Confidential

OT PT ST DME

I hereby give permission to Paramount Rehabilitation Services to evaluate and treat and/or provide DME product(s). I agree to be financially responsible for all charges incurred at Paramount Rehab, including my co-payment and insurance deductible. I further understand my insurance may not cover the services provided. I understand that if my insurance company does not pay for these services, then I will be responsible for any bill that is accrued. Furthermore, I authorize my insurance company to pay directly to Paramount Rehab Services under the terms of the policy issued by my company. Payment is authorized upon your receipt of any itemized bill for services rendered to me. Payment of the amount, on whole or in part, shall be considered the same as if paid by your company directly to me

Patient
Signature:____**Date:**_______________

Parent/Guardian
Signature: ____**Date:**______________

Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned patient or legally authorized representative ("agent") of the patient acknowledges that he or she is aware of the privacy practices of this facility (HIPAA). If undersigned patient is unaware of these policies, he or she is aware that a copy will be made available upon request.

Patient
Signature:____**Date:**_______________

Parent/Guardian
Signature: ____**Date:**______________

No Show/Cancellation Policy

I understand that if I do not come to an appointment or do not cancel with a 24 hour notice, I will be charged $25.00 for that visit. The $25.00 will <u>not</u> be billed to my insurance company. I understand that I will be responsible for paying the $25.00 fee on the next visit.

Patient
Signature:____**Date:**_______________

Parent/Guardian
Signature: ____**Date:**______________