

BRAINTREE REHABILITATION HOSPITAL  
AMBULATORY CARE AUTHORIZATION

**CONSENT FOR CARE AND TREATMENT**

I \_\_\_\_\_ hereby voluntarily authorize BRAINTREE REHABILITATION HOSPITAL to perform outpatient diagnostic evaluation(s) and/or procedure(s) and to administer such outpatient therapy treatment(s) that in the opinion of the physician and consulting allied health personnel is/are necessary or appropriate.

Initials \_\_\_\_\_

**BENEFIT ASSIGNMENT**

The undersigned agrees, whether he/she signs as agent or as patient, to direct payment to the Hospital of any insurance benefits otherwise payable to, or on behalf of, the patient for this hospitalization or outpatient services, including emergency services if rendered, at a rate not to exceed hospital's regular charges.

Initials \_\_\_\_\_

**RELEASE OF INFORMATION**

The hospital may disclose all or any part of the patient's medical records to any person or corporation that is liable for the Hospital's charge. This includes insurers, payors, reimbursers, or utilization review companies. The release is strictly for **reimbursement** purposes to the Hospital for services rendered.

The hospital may also release medical records to referring physicians and other treatment providers for continuation of **treatment**.

Initials \_\_\_\_\_

**FINANCIAL POLICY STATEMENT**

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered. **We require that arrangements for payment of your estimated share be made today.** If your insurance does not remit payment within 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance in excess of the balance of your account, we will promptly refund the credit.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised as a Compensation patient that you may be held responsible for your charges in the event your claim is denied.

**ESTIMATED INSURANCE COVERAGE**

Your insurance company has initially authorized \_\_\_\_\_.

Your financial responsibility will be: \$\_\_\_\_\_ per visit per discipline as determined by your insurance company.

**OR** your co-insurance or deductible as determined by your insurance company.

NOTE: Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance.

**All copayments are required prior to each visit.**

Initials \_\_\_\_\_

**MANAGED CARE COVERAGE**

I acknowledge that I do not have a referral today, and will be responsible for payment of all services rendered should my health insurance carrier deny them.

Initials \_\_\_\_\_

**COMPLAINT/GRIEVANCE PROCEDURE**

The patient shall be fully informed of the Hospital Complaint/Grievance Procedure at the time of admission as well as receiving a copy of the procedure. The undersigned acknowledges a receipt of this information.

Initials \_\_\_\_\_

***The above form has been read and/or explained to me. I UNDERSTAND MY RESPONSIBILITY FOR PAYMENT OF MY ACCOUNT. BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, OR HAVE HAD READ TO ME, THIS FORM.***

\_\_\_\_\_  
Patient/Guardian or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
BRAINTREE REHABILITATION HOSPITAL Representative

\_\_\_\_\_  
Date