RAINBOW REHAB
PHYSICAL & OCCUPATIONAL THERAPY
HAND REHABILITATION

RAINBOW REHAB, LLC
PATIENT AUTHORIZATION FORM

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I understand that Rainbow Rehab. LLC is required by law to maintain the privacy of medical information and provide me with a copy of its Notice of Privacy Practices. I acknowledge that I have been given Rainbow Rehab's Notice of Privacy Practices.

MEDICARE PATIENTS

I have been informed of the new Medicare cap for outpatient therapy services.

INSURANCE PAYMENT/ASSIGNMENT OF BENEFITS

I authorize payment of Medicare/Insurance benefits to be made directly to Rainbow Rehab, LLC on my behalf for physical/occupational therapy services rendered. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

SECONDARY INSURANCE

I request that payment of authorized secondary insurance benefits be made to Rainbow Rehab, LLC on my behalf for physical/occupational therapy services rendered. I authorize any holder of medical information about me to release to the secondary insurance and its agents any information needed to determine these benefits or the benefits payable for related services.

FINANCIAL RESPONSIBILITY

If I do not have a secondary insurance or if my secondary insurance does not pay Rainbow Rehab, LLC, I understand that I am responsible to pay Rainbow Rehab, LLC directly the balance that the insurance does not cover. Please note all co-pays, deductibles and/or co-insurance is the patient's/guardian's (in case of minor) responsibility. Co-pays are due at the time services are rendered.

SIGNATURE ON FILE

I have read, understand and agree with the above policies and procedures.

Patient Name (print) _____

_____ _____

Patient's / Guardian's Signature Date