Receipt of Notice of Privacy Practices, Patient Responsibility Agreement & Consent for Care and Treatment

I, _____ (print name) acknowledge receipt of a copy of the Company's **NOTICE OF PRIVACY PRACTICES AND PATIENT RESPONSIBILITY AGREEMENT**.

***Patient Signature:** _____

Date: _____

How May We Contact You

I may be contacted at (please check all that apply):

____ Primary (_____) _____-_____

____ Secondary (_____) _____-_____

____ Email _____

Best day(s) and time(s)_____

Insight Wellness May Leave:

____ a detailed message with a family member or significant other

Name _____ Relationship _____

____ a detailed message on an answering machine or voicemail box

____ just a call back number with NO INFORMATION

***Patient Signature:** _____

Date: _____

CONSENT FOR CARE AND TREATMENT

I, _____, give my consent to Insight Rehab & Wellness PLLC to furnish medical care and treatment that is considered necessary and proper in diagnosing or treating my physical and medical condition.

AUTHORIZATION OF BENEFIT ASSIGNMENT . FINANCIAL RESPONSIBILITY & RELEASE OF INFORMATION

I authorize Insight Rehab & Wellness PLLC to release to the insurance carrier any information needed for the

****THIS PAGE IS DOUBLE SIDED, SIGNATURES NEEDED ****

payment of any claim. I authorize payment to Insight Rehab & Wellness PLLC. from my insurance carrier or third-party payer. I agree to pay any applicable copayments and balances at the time of service as agreed between **Insight Rehab & Wellness PLLC** and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or **a third-party** payer. I understand that if I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, legal fees**,** and the 28% collection agency fees above and beyond the owed balance.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have read and understand the Insight Rehab & Wellness PLLC Notice of Privacy Practices. I understand that by signing this consent, I am giving my permission to Insight Rehab & Wellness Pllc to use and disclose my protected health information to carry out treatment, payment activities, and health care operations. I understand the terms of this notice may change with time and Insight Rehab & Wellness PLLC. will always post the current notice at the clinic, on the website, and have copies available for distribution.

Indicated below are person(s) whom Insight Rehab & Wellness PLLC. may speak with regarding my treatment:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

Listed below are individual (s) whom I request RESTRICTION regarding my protected health information.

_____

****SIGNATURE FOR CONSENT ****

By my signature below, I acknowledge that I have read, understood and agreed to the terms and conditions contained in the ***Consent for Care and Treatment***, the ***Authorization*** to release all information necessary to secure payment and the ***Consent For Use and Disclosure of Health Information***.

_____/_____/20__

Signature of Patient/Guardian/Responsible Party Date