Northwest Rehabilitation Associates, Inc.

Northwest Rehabilitation Associates: Conditions of Patient Registration

Medical consent: I wish to be registered as a patient of Northwest Rehabilitation Associates, Inc (hereafter NWRA). I authorize NWRA to provide routine rehabilitative services that the staff feels are necessary to improve to stabilize my condition. I understand that this may include but not be limited to tests, examinations, therapeutic exercises and activities modalities, or procedures. I understand that the therapists treating me may be independent contractors not employed by NWRA. I may be used for photographed or videotaped to document my medical treatment or condition and that this may be used for educational purposes.

Authorization to Release Information: I authorize NWRA to release from my medical records any information required by my insurance carrier or any person, corporation, or agency responsible for processing my claims for medical benefits I further allow information from my medical record to be used for medical studies with the understanding that the information will be held confidential. The people who may view my record may be anyone involved in my care including, but not limited to NWRA employees, employees of my insurance company, employees of my physician or nurse practitioner, consultants, or their agents. This review may include release of information from my medial record while I am in the care of NWRA, or after discharge, and it may include discussions about my care with my physicians or others who care for me, my family or myself. I understand that if an insurance company or government agency is paying for my care, they may have access to sensitive information about my diagnosis and treatment. This authorization is valid for the life of the claim. I further authorize release of any or all of my medical record to the offices of any examining, consulting or referral physician whether or not I have personally seen the physician. Please inform any member of our staff if you would like a copy of our HIPPA policy. Our HIPPA officer is Mike Studer.

Financial Agreement: I agree to pay NWRA according to the regular rates and terms for the services to be rendered to me. **I understand that I am financially responsible for charges not covered by my insurance or other agency. I understand that I am responsible for any deductible and coinsurance.** If my insurance requires referral from my Primary Care Physician and NWRA has not received authorization from my Primary Care Provider, I will be financially responsible for any and all charges not covered by my insurance. If this account is placed in the hands of any attorney for collection, I will pay reasonable attorney's fees and collection costs, whether or not a suit is filed. All accounts are payable in full at time of billing; a courtesy period of 30 days is given. If after 30 days the insurance payment is not received, the balance in full becomes my responsibility. If my account becomes past due, I may be required to pay interest on the unpaid balance.

Assignment of insurance benefits: I authorize payment directly to NWRA of all insurance or health plan benefits otherwise payable to me, to the extent of my bill.

Medicare Certification and Payment Request: If I am applying for payment under Medicare or Medicaid, I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf.

I certify that I have read the conditions of patient registration. I am the patient, or I am authorized as the patient's agent or representative to execute the agreement and accept its terms on behalf of the patient. I assume individually all financial responsibility by signing below.

___/___/20___	X______________________________	______________________________
Date	Patient or representative signature	Witness