

CONCORDIA OUTPATIENT THERAPY PATIENT AUTHORIZATION FORM



Patient Name: _____

Release of Information and Consent to Treatment

I am aware of my diagnosis and wish to receive treatment at Concordia Lutheran Ministries Outpatient Services. I permit its employees and all other employees caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Concordia Lutheran Ministries to release my information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.

I authorize Concordia Lutheran Ministries and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

These initials _____ certifies that I have read and understand the above information.

Assignments of Benefits

I authorize payment directly to Concordia Lutheran Ministries for services. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

These initials _____ certifies that I have read and understand the above information.

HIPPA Acknowledgement/Consent

I hereby acknowledge that I have received a copy of The Notice of Privacy Information Practices for Outpatient Rehabilitation Services. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care options.

These initials _____ certifies that I have read and understand the above information.

Social Service Assessment

I being a recipient of professional services from Concordia Lutheran Ministries, hereby declare that I have no need or desire to receive social services through the previously mentioned party.

These initials _____ certifies that I have read and understand the above information.

Payment Guarantee

I agree to pay Concordia Lutheran Ministries for the services provided to me or the party named above. If any law, such as worker's compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any type of information necessary to allow for timely collection from my third party payer. Where the insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. Concordia Lutheran Ministries will bill your claim directly to your insurance carrier based on the information you have provided. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Concordia Lutheran Ministries

Patient or Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____