AOB CONSENT AND ACKNOWLEDGEMENT FORM

Consent for Rehabilitation Services. I consent to *The Summit Health and Rehab Services, Inc.'s* implementing a Physical / Occupational / Speech treatment program for

_____ as prescribed by a physician.
(Patient Name – Please Print)

Patient or Responsible Party Initials _____

Consent to Release Information. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I consent to any holder of medical or other information about me releasing to the Social Security Administration or its intermediaries or carriers or to any other third party carrier(s) from whom I may seek reimbursement for expenses related to my treatment any information needed for this or a related claim.

Patient or Responsible Party Initials _____

Assignment of Benefits. I request that any payment of authorized benefits for which I am entitled and which are otherwise payable to me and related to this claim be made on my behalf directly to *The Summit Health and Rehab Services, Inc.*

Patient or Responsible Party Initials _____

Guarantee. *The Summit Health and Rehab Services, Inc*. will bill for all insurance carriers provided. In consideration for treatment, I agree to pay all deductible ($183.00 per year or other published amount for Medicare Part B) and co-insurance (20% of charges for Medicare Part B) amounts related to services rendered. In the case of available secondary insurance carriers, co-insurance amounts may be covered by the secondary insurance carrier.

I understand that as a courtesy to me, my charges will be billed to my insurance carrier. However, I understand that I am ultimately responsible for all charges incurred.

Patient or Responsible Party Initials _____

Acknowledgment of Receipt of Notice of Privacy Practices. I understand that I am entitled to a copy of *The Summit's Notice of Privacy Practices*, that such Notice is offered to the patient at initiation of treatment, and that this Notice is also available in the therapy treatment area and on The Summit's website. I hereby acknowledge that I have received and had an opportunity to ask questions concerning *The Summit's Notice of Privacy Practices.*

Patient or Responsible Party Initials _____

I have read and initialed all of the above and I certify that I understand and agree to its content.

_____ _____
Date Patient or Responsible Party Signature

_____ _____
Date Witness Signature

_____ _____
Date Therapist Signature