SERVICE • ACCESS • OUTCOMES
PROGRESSIVE
REHABILITATION ASSOCIATES

Patient Information Consent Form

Consent to Evaluation and Treatment:

I hereby authorize PRA, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed medically necessary by my physician and therapist in the treatment of my (or the individual that I am legally responsible) condition.

Notice of Privacy Practices:

By signing this form, you acknowledge that you have been offered a copy for review of PRA's Notice of Privacy Practices which is available both in the clinic and on our website. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice and if you have any questions about our Notice of Privacy Practices, please contact our Director of Operations at (319) 338-5800.

Release of Information:

I hereby authorize PRA the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Communication:

I hereby authorize PRA to communicate with me through cell phone, home phone, and/or email.

Designated Individual Authorization:

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. If none, please print "none" below.

Authorized Designees:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Assignment of Benefits and Financial Responsibilities:

I hereby authorize payment of medical benefits to PRA for services rendered. I understand that in accordance with my health insurance policy I may have a co-pay, co-insurance, or balance due that is my responsibility. I understand that my co-pay and co-insurance are due to at the time of service, and that PRA reserves the right to refuse further treatment until my prior balance due has been satisfied.

I have read the above information and agree to this in its entirety:

Patient Signature:_____Date:_____

Responsible Party:_____ Date:_____

(Signature required if patient is under 18 years of age)