**Rehabilitation Institute of Kansas City (RIKC)**

Patient Label

# TREATMENT AND PAYMENT ACKNOWLEDGMENT/CONSENT

## Consent for Treatment

I hereby authorize RIKC, the attending physician(s) and other practitioners designated by them (hereinafter collectively referred to as "RIKC") to prescribe treatment, to administer medications, and to perform such procedures and tests as may be deemed advisable or necessary in the treatment of this patient. I understand that no promise, guaranty or warranty has been made regarding the results of medical rehabilitation treatment or procedure. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury. I acknowledge that no guarantees have been made to me as a result of evaluation, treatment or recommendations by RIKC.

## Obligation of Payment

I irrevocably direct and assign payment from my insurance company, Medicaid, Medicare, Tricare, or other provider of health care benefits to RIKC for services rendered. I understand that my insurance policy is a contract between my insurance company and me, and that I am responsible to RIKC for any charges not covered by my insurance, including co-payments, deductibles, and fees for non-covered services.

The undersigned understands and agrees that RIKC is not responsible for collecting insurance nor for resolving any disputed insurance or other third party payer claims, and promises to pay RIKC all costs and charges incurred in connection with services received. ***It is agreed that any benefits quoted by any insurance company and/or RIKC staff are not a guarantee of payment and that it is my responsibility to contact the insurance company to determine actual benefits.*** It is agreed that if a full payment is not made by insurance or other third party payers within thirty days, the undersigned shall make payment in full.

## Balances Due and Billing Questions

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. Co-payments and other self-pay amounts are due prior to discharge.

## Authorization to Release Information

I understand and agree that according to law, HIPAA requires and allows RIKC to perform the following:

1. The verbal and/or written release of all or any portion of the medical records of the undersigned patient to any health care practitioner or facility that may be designated for the purpose of providing continuing and future medical care.

2. Disclosure of medical information pertaining to treatment of the undersigned patient to the appropriate health insurance company that is necessary for the purposes of certification, payment of medical expenses, and discharge planning. RIKC therapy team members communicate with each other regarding my treatment and progress verbally and in my written medical records. It may include information about my therapies (PT, OT, SP), neuropsychology services, rehab counseling and social services. *It may also contain information such as treatment for drug or alcohol abuse or hepatitis or HIV/AIDS.*

## Acknowledgement/Certification

I, the Parent/Legal Guardian/Patient, acknowledge and certify the following:
I certify that this form has been fully explained to me and I understand the contents of this form. I am the patient or the patient's parent/legal guardian and have the authority to request this treatment. Furthermore, I permit a copy of this document to be used in place of the original. I certify that all statements are true and correct and I understand that false statements or documents or concealment of a material fact may be prosecuted under federal or state laws.

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| Print Patient Name | Patient Date of Birth | |
| Signature of Patient/Legal Guardian | Relationship to Patient | Date |
| Witness Signature | Date | |

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MEDICAL REHABILITATION | EMPLOYMENT PLACEMENT | DISABILITY SERVICES