FAIRVIEW

TRUSTED FOR GENERATIONS

Outpatient Consent to Treat and Bill

1. AUTHRIZATION:
    a. I hereby authorize Fairview to provide such medical care and to administer such treatment, necessary to the named patient or me each time I or the named patient presents to Fairview's Outpatient Rehabilitation Program. Such procedures and treatments may include Physical Therapy, Occupational Therapy, & Speech Therapy.
    b. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatments.
2. MEDICARE PATEINTS:
    a. I authorize any holder of medical or other information about me to be released to the Social Security Administration, its intermediaries, carriers, and information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment on medical insurance benefits either to myself or to the party who accepts assignment below.
3. GUARRANTEE OF ACCOUNT:
    a. For and in consideration of services rendered to _____ by Fairview, I hereby agree to pay the full bill for all charges which are not paid to Fairview by insurance carriers, Workers Compensation, Not-fault or any balance due which is not covered by insurance or excluded by a co-insurance clause.
4. RELEASE OF INFORMATION:
    a. I permit Fairview to disclose all or part of the above patient's medical records to any person, corporation, or agency, when required for the collection of benefits or payment of Fairview charges. I confirm that have read and fully understand the above.

Relationship (If signed by person other than patient): _____

(Print name, Signature and Date)

Fairview Authorized Representative:

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