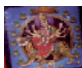

VANITA'S REHAB

31 NELSON AVENUE,
MELBOURNE, FL 32935
Website: www.vanitasrehab.com
Phone: 321-432 5573 Fax: 321-726 9938

Authorization For Medical Treatment/Physical Therapy

By signing in the space provided as Patient/Surrogate/Guardian/Spouse, I hereby agree and give my consent for the Physical Therapist/Assistant at Vanita's Rehab to furnish the physical therapy care and treatment deemed by the Physician, Physical Therapist/Assistant, or other provider to be necessary and proper in evaluating and healing my/their physical condition.

Signature: ____________________________ Date:_________________

Authorization To Release Benefit Information

I hereby authorize and request ____________________________ (Insurance Company) to release All benefit information to Vanita's Rehab.
Patient Name: __________________________ Claim # (if applicable): ______________________
Date of Accident (if applicable): __________

Signature: ____________________________ Date:_________________

Authorization To Release Medical Records

I hereby authorize Vanita's Rehab, or other medical representatives who have attended to me to furnish my insurance company (ies) listed above or their representatives with any and all information that may be contained in their medical records.

Signature: ____________________________ Date:_________________

Assignment of Insurance Benefits

I hereby authorize payment directly to Vanita's Rehab of the physician's benefits otherwise payable to me by my insurance. I understand that Vanita's Rehab is not responsible for the terms of the Contract(s) which I have with my Insurance Company (ies), which may determine to pay all, some, or none of the charges resulting from my medical care. I also understand that I am financially responsible to Vanita's Rehab for charges/benefits not covered by my insurance and promise to pay immediately on demand. **I hereby certify that I am NOT under Home Health Care (Please note you will be personally responsible for payment for this service if this turns out not to be true, as insurance will deny claims). I agree to pay $50 appointment cancellation fee if I cancel my appointment without giving 24 hour notice**.

Signature: ____________________________ Date:_________________

Tel: _____________________ e-mail: ___________________________