Northside Office
980 Johnson Ferry Road, NE
Suite 1000
Atlanta, GA 30342
404-255-1242

Alpharetta Office
3400A Old Milton Parkway
Suite 350
Alpharetta, GA 30005
404-639-9098

Consent for Care and Treatment

I, undersigned, do hereby agree and give my consent for *The Hand and Upper Extremity Rehabilitation Center of Georgia, L.L.C.* to provide medical treatment that is considered necessary and proper in diagnosing and treating my physical condition.

Patient / Guardian / Responsible Party Date

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance payors to *The Hand and Upper Extremity Rehabilitation Center of Georgia, L.L.C.* A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records to secure payment for all rendered services .

FINANCIAL POLICY STATEMENT

We will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when services are rendered. We require that arrangements for payment of your estimated share be made today and at the time of service. If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. In the event that your insurance carrier requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance carrier. In the event that your insurance carrier establishes an internal *usual and customary fee schedule* you will be responsible for the difference remaining. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to *The Hand and Upper Extremity Rehabilitation Center of Georgia, L.L.C.*

The above may not apply for those patients that are entitled to Worker's Compensation or who have benefits with a balance billing contract, such as an HMO. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

The Hand and Upper Extremity Rehabilitation Center of Georgia, L.L.C. verifies benefits as a courtesy to you. However, The Hand and Upper Extremity Rehabilitation Center does not accept responsibility for incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits or benefit plans.

When you pay by check, you expressly authorize *The Hand and Upper Extremity Rehabilitation Center of Georgia, L.L.C.* , if your check is dishonored or returned for any reason, to electronically debit your checking account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus all applicable sales tax). Please note: the above language authorizes an electronic debit from your account for the state allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for electronic transaction. This does not, however, mean that *The Hand and Upper Extremity Rehabilitation Center of Georgia, L.L.C.* cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, I will be responsible for all costs of collecting monies owed, including but not limited to court costs, collection agency fees, and attorney fees.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient / Guardian / Responsible Party Date

Center Representative / Witness Date