UNITY HEALTHCARE, LLC – MIRACLES REHABILITATION
DISCLOSURE AND RELEASE AUTHORIZATION FORM

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as my physician, in his/her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

_____ **Initials**

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Unity and my physician to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

_____ **Initials**

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or $300.00, whichever is greater.

_____ **Initials**

TELEPHONE CONTACTS: I authorize Unity Healthcare, LLC and its affiliates and agents to contact me at the phone numbers I have provided (whether such is a cell phone or a land line), including providing me with automated appointment reminders and other automated calls related to the services provided to me. If a machine or voice mail is reached I understand a message may be left for me. (If you are receiving treatment from multiple Unity Healthcare providers, it may result in multiple calls.)

_____ **Initials**

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been offered a copy of the Unity Healthcare's Notice of Privacy Practices and understand that my protected health information ("PHI") may be used by Unity as described in such Notice.

_____ **Initials**

INDIANA LAW AND JURISDICTION: I understand that I am being provided treatment in the State of Indiana and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Indiana law and such action will be brought and decided in a Court in the State of Indiana.

_____ **Initials**

NOTICE OF NONDISCRIMINATION: Unity Healthcare, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or gender identity.

_____ **Initials**

OTHER PROVIDERS: I understand in addition to the attending physician, other physicians, such as radiologists and pathologists, and other providers such as laboratories and other medical professionals, may be involved in my care, and may separately bill me for their services.

_____ **Initials**

HOME HEALTH DISCLOSURE: I am presently NOT "under contract with" or "currently receiving" any Rehabilitative Home Health Services.

_____ **Initials**

CANCELLATIONS OR MISSED APPOINTMENTS: A fee may be charged for any appointments not cancelled at least 24 hours in advance or missed for any other reason. These are generally not payable by insurance.

_____ **Initials**

MEDICARE CERTIFICATION: (IF APPLICABLE) I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to my treating physician on my behalf.

_____ **Initials**

Patient Name/Signature: _____ Date:_____

Parent/Guardian Signature: _____ Date:_____