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D & W Rehab, Inc.
Counseling and Rehabilitation Professionals

Stacy Pettit, MBA, OTR/L
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CONSENT TO PAYMENT

I have listed all health insurance plans from which I may receive benefits. I hereby authorize payment of medical benefits billed to my insurance to D & W Rehab, Inc. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if D & W Rehab, Inc. does not participate with my insurance. I agree to pay all co-payments, co-insurance, and deductibles at the time services are rendered. I, _____, hereby authorize D & W Rehab, Inc. to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and health care operations.

I understand that while this consent is voluntary, if I refuse to sign this consent, D & W Rehab, Inc. can refuse to treat me.

I understand that D & W Rehab, Inc. has reserved the right to change their privacy practices and that I can obtain such changed notice upon request. I understand that I have the right to request D & W Rehab, Inc. restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health operation. I understand that D & W Rehab, Inc. does not have to agree to such restrictions, but that once such restrictions are agreed to, D & W Rehab, Inc. must adhere to such restrictions.

_____ DATE: _____
Signature of Patient or Patient's Representative

Printed Name of Patient: _____

Relationship of Representative to Patient: _____