

## West Texas Rehabilitation Center

Patient's Name: \_\_\_\_\_ Master Chart: \_\_\_\_\_

### Consent for Treatment:

*I, the undersigned, am the patient (or guardian, Healthcare Power of Attorney, or the patient's duly authorized representative) and do hereby voluntarily consent to and authorize West Texas Rehabilitation Center, Inc., a Texas non-profit corporation, or other related entities to administer treatment as per the doctor's orders.*

### Assignment of Benefits and Authorization to Release Information:

*I hereby assign to WTRC all benefits provided under any healthcare plan, medical policy, motor vehicle insurance, and/or any other entities paying on my behalf, otherwise due or payable to me provided the amount of such benefits shall not exceed the amount of said professional service charges. I understand that I am personally responsible to WTRC for all charges not covered by this assignment and that a photocopy of this Assignment shall be considered as effective and valid as the original.*

*I also authorize the release of any records/information, including papers, forms, videos, photographs and other records pertinent to my case, to any insurance company, adjuster, medical case manager, employer, physician or other medical entity, or attorney involved in this case.*

### Payment Policies:

- 1. Although you may be assisted by private insurance, Worker's Compensation, Medicare, Medicaid, or even WTRC's Donor Sponsorship Program, payment for services received by you or your family is ultimately your responsibility. Cash, personal checks, MasterCard, American Express, Discover and Debit cards are accepted.*
- 2. Payment is required at the time of service if you have an insurance plan that dictates a per visit co-payment. Patients who do not have such a feature in their insurance coverage will be mailed a statement indicating their financial responsibility for the services provided.*
- 3. WTRC is committed to assisting families with their financial responsibilities. The Donor Sponsorship Program is designed to identify families with various levels of need and provide them with corresponding assistance. Our staff will be glad to assist you in determining your eligibility for assistance. Before that process can begin however, we need to know that you would like to seek assistance and are willing to provide the needed information.*

*WTRC hopes that this information helps to clarify our policy. If at any time you have a question or you would like to be reconsidered for sponsorship based on new information, do not hesitate to ask the Admission staff.*

**Third Party Disclosures:**

*I, \_\_\_\_\_, give the following person(s) or representative(s) permission to discuss my appointments, medical treatments and any financial matters on my behalf.*

\_\_\_\_\_

\_\_\_\_\_

*(Please circle yes or no)*

*Y N I grant permission for WTRC personnel to leave messages on my home voice mail.*

*Y N I grant permission for WTRC personnel to leave messages on my work voice mail.*

*I have been offered a copy of the appropriate orientation to West Texas Rehabilitation Center.*

*I have been offered a copy of the Notice of Information Practices in the WTRC Patient Handbook which describes how medical information about you may be used and disclosed and how you can get access to this information. If after reviewing the Notice, should you have any questions our admission staff would be glad to answer them.*

\_\_\_\_\_  
**Signature of Patient or Guardian**

\_\_\_\_\_  
**WTRC Witness**

\_\_\_\_\_  
**Date**