CONSENT TO TREAT

_____ I, the undersigned, hereby authorize the Doctors of Empire Rehab and whomever they may designate as their assistants to perform diagnostic tests and to administer treatment as is necessary to me. I also certify that no guarantee or assurance has been made to the results that may be obtained.

CONSENT FOR TREATMENT OF MINOR

_____ I hereby authorize the Doctors of Empire Rehab and whomever they may designate as their assistants to perform diagnostic test and to administer treatment as he/she deems necessary to my child.(Child's name) _____ of which I am the legal guardian

ATTORNEY REPRESENTATION AND BALANCE PROTECTION

_____ I, the undersigned patient, am instructing my Attorney, _____, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment as services are rendered. I have agreed to pay, in the current manner, any balance of said applicable charges out of the proceeds of my settlement and understand that my attorney will be billed for said balance. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts of payment of my outstanding medical bill.

PAYMENT POLICY

Please initial ONLY IF you are utilizing any of the following

____Health Insurance: Proof of Insurance must be provided in order for us to file claims with your insurance company. Please understand that benefits through health insurance policies differ. Insurance companies pay according to your individual policy limits. Benefits are between you and your insurance company. You with your insurance company must handle any discrepancy regarding benefit coverage. Any portion of your bill that is not paid by your health insurance will be billed to your Attorney and will be paid at the time of your settlement.

_____ Auto Insurance: We do not file against the adverse driver's insurance in an automobile accident. If MED PAY is available, we can and will file against either your automobile insurance, or the owner of the vehicle you were a passenger in. If medical benefits are available there may be a maximum allowable amount of coverage, which may not cover all charges in full. In that event you will be responsible for the remaining balance and your Attorney will be billed.

Do you have Medpay? Yes _____ Please provide a Copy of Insurance **No** _____

_____ Worker's Compensation: We will file with your workers compensation insurance company upon approval of each visit or procedure by the proper authority in the case. Should the case be controverted or denied for any reason we cannot file with the workers compensation insurance on future claims, and you will be responsible for the unpaid claims unless financial arrangements with your attorney have been made.

DISCLOSURE

_____ I hereby acknowledge I have been informed that Empire Rehab may have a mutual/common vested interest in the services provided by Empire Rehab Clinics and Diagnostic Testing companies. I understand I may choose another facility for the services I require and have elected to receive care at this clinic.

APPOINTMENT ATTENDANCE AGREEMENT:

_____I understand the importance of attending the scheduled medical appointments consistently and arriving promptly for my appointments. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment can result in a cancel/no show charge of $50.00. This fee will not be billed to the attorney on file, and I will be responsible for these charges.

PATIENT REFUND POLICY

The doctors of New South Medical expect to be paid by the first available means whether by health insurance, med pay or settlement of your case. Should an overpayment be made, and you have a credit balance on your account, a refund will be issued to either you or the appropriate party.

I understand and agree to abide by all of the information above.

Print Name: _____ (Patient/Guardian Printed Name)

Signature:_____ Date:_____