Authorization/ Consent to Provide Care and Bill Insurance

I am hereby consenting to treatment as may be deemed necessary or advisable in the diagnosis and treatment of my care.

I give my authorization to use or disclose my protected health information (medical records) that may be required in order to administer any treatment deemed necessary in the diagnosis and treatment of my care.

I hereby authorize payment directly to Restore Occupational Therapy from my necessary insurance company.

Patient/Guardian Signature Date

Financial Responsibility / Waiver Form

Dear Patient:

Positive verification of your coverage cannot always be made at the time of service. You will receive services with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible for these services rendered.

Patient's Name Insurance Carrier

I have read the above and understand my possible financial responsibility of services rendered and hereby affix my signature as an acknowledgment of this understanding.

Patient's Signature Date