BATESVILLE THERAPY CLINIC, Inc.

Conditions for Treatment

CONSENT TO TREATMENT: This is to certify that I, the undersigned, hereby consent to and authorize the administration and performance of all occupational and or physical therapy procedures in which my attending physician or his agent have considered to be necessary or advisable. No guarantee has been made as a result of treatments received by Batesville Therapy Clinic. The above authorization shall expire upon the discharge of the patient from Batesville Therapy Clinic.

RELEASE OF INFORMATION: I authorize Batesville Therapy Clinic at its discretion, to disclose any or all of the information in my medical records to any person, corporation or agency which is, or may be, liable for all or part of the Therapy Clinic's charges or, who may be responsible for determining the necessity, appropriateness, amount, or other matter related to the Clinic's treatment or charge, including, but not limited to the insurance company, its representative, a IIMO, PPO, W/C carriers, welfare funds, Medicaid programs, or the Medicare program it's intermediary or carriers. I further authorize the Batesville Therapy Clinic, in its discretion, to disclose such information to its insurance carrier or carriers when so requested. All past and present patient care records will be available to any physician who has, is, or will treat any medical condition of the undersigned.

ASSIGNMENT OF THERAPY CLINIC BENEFITS: I authorize payment directly to the Batesville Therapy Clinic accepting this assignment of all medical benefits applicable and otherwise payable to me but not to exceed the reasonable and customary charge for these services by said Therapy Clinic. I understand I am financially responsible to Batesville Therapy Clinic for the charges not covered by this authorization.

FINANCIAL AGREEMENT: I understand that although the patient and others may also be responsible for paying this account by virtue of an express or implied agreement, or otherwise, I shall be responsible to pay the entire account, and I further understand that this agreement in no way relieves any such other party of any obligation to pay this account, I understand and agree that the account is due in full each week or upon discharge whichever occurs earlier, with allowances made for insurance coverage approved and verified prior to discharge.

PATIENT'S CERTIFICATION, AUTHORIZATION: I certify that the information given by me in applying for payment under the Title XVIII of the social Security Act is correct. I authorize any holder of medical or other information about me be released to the Social Security Administration intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits by made on my behalf.

PROFESSIONAL COMPONENT AUTHORIZATION: I assign payment for the unpaid charges to Batesville Therapy Clinic for services furnished for Occupational and or Physical Therapy Services. I understand that I am responsible for any health insurance deductibles and co-insurance.

THE UNDERSIGNED CERIFIES THAT HE/SHE HAS READ THE FOREGOING, IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATINET TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS THEROF.

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Patient/ Authorized Legal representative

_____/_____/_____ _____

DATE **WITNESS**