

5934 U.S. Hwy 6
Portage Commons
Portage, Indiana 46368
Ph. (219) 762-7136
Fax (219) 762-5148



1. GENERAL CONSENT TO MEDICAL TREATMENT

I request and authorize Rohe Therapy, Inc., its agents and employees who may attend me during outpatient visit, to provide and perform physical therapy. I understand the practice of physical therapy is not an exact science and that no representations, warranties, or guarantees have been made by Rohe Therapy as to the outcome of the treatments.

2. RELEASE OF INFORMATION

I authorize Rohe Therapy, Inc. to release a copy of my medical records and to release any other information necessary for the provider to obtain payment from my insurance carrier or third-party payor including Medicare and Medicaid benefits for services rendered to me by Rohe Therapy, Inc. I further authorize Rohe Therapy, Inc. to disclose information concerning my medical condition to any other health care provider who is involved in providing me care or treatment.

3. PERSONAL PROPERTY

Rohe Therapy is not responsible for any loss of or damage to a patient's property.

4. FINANCIAL RESPONSIBILITY

- I assign directly to Rohe Therapy, Inc. the payment of my health insurance benefits which are due for this treatment.
- I also certify that the information given in applying for payment under Medicare and/or Medicaid is true and correct.
- If I fail to pay for these services, I agree to pay the collection agency fees, reasonable attorney fees and court costs incurred in collecting the debt.

PATIENT/LEGAL REPRESENTATIVES SIGNATURE	RELATIONSHIP TO PATIENT	DATE	WITNESS
FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN ABOVE)	RELATIONSHIP TO PATIENT	DATE	WITNESS