REHABILITATION SERVICES CONSENT FORM

Patient name: _____

Address: _____

Phone # _____

D.O.B. _____

Email: _____

Part one: Consent for OT/PT/SLP Assessment:

I, the undersigned patient or parent/guardian of the patient, authorize the MD Neuro- Rehab &Wellness Center to provide skilled rehab services as deemed necessary and appropriate for .

_____

I understand the results of the assessment, treatment and recommendations will be discussed with me, and will be provided to my designated health-care provider upon request.

Signed:_____ Date_____

Relationship to patient _____

Part Two: Consent to collect payment

I, the undersigned patient or parent/ guardian, authorize MD Neuro-Rehab & Wellness Center to:

Collect an out of pocket payment amounting to: not more than $110/session if insurances do not cover an assessment/ treatment per session.

Signed:_____ Date_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.
By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- · Protected health information may be disclosed or used for treatment, payment, or healthcare operations. · The practice reserves the right to change the privacy policy as allowed by law.
- · The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- · The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. · The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES__ NO__

May we leave a message on your answering machine at home or on your cell phone?
YES___ NO__

May we discuss your medical condition with any member of your family? YES__ NO___

If YES, please name the members allowed : _____

Name_____Signature_____

Date Signed_____

Permission for Release of Medical Records

I _____ grant MD Neuro-Rehab & Wellness center permission to release my private health information to relevant my healthcare plan and services. This information may be made available to

- Healthcare providers
- School officials
- Health Organizations with which I may be associated now or in the past, or be a candidate for future services.

All relevant health information may be released without further authorization by myself. This form has no date of termination and is to be used for ongoing services.

Signature:_____ Date Signed _____

Maryland Neuro-Rehab & WELLNESS CENTER

No Show and Cancellation of Appointment Policy

Effective January 21, 2021

Life happens! We get that and we are glad to work with you through the unanticipated life events that alter your well-made plans. In order to do so it is important to keep your scheduled appointment with your therapists and notify us early if something comes up and you need to cancel or reschedule. By notifying us early we can stay on track with your rehab program and achieve your health and wellness goals.

Please make sure to note your appointment date and time on your calendar and arrive on time, or let us know if you are running late. You will also receive a text message reminder from us on the day prior to your scheduled appointment. In the event that you need to reschedule or cancel your appointment please call/text or email 24 ***hours prior*** to your scheduled appointment.

By signing this form you agree to pay a non-refundable charge of $50.00 for each last-minute cancellation, made within ***less than 24 hours prior to your scheduled appointment.***

Below are the numbers where you can reach us for schedule changes. Please don't hesitate to reach out to us if a problem arises and you need to reschedule. We are happy to help!

P: 443-360-5527
Email: LaTanya@Neurorehabmd.com

Thank you for working with us to ensure that services are provided to all of our patients in the best possible way.

Acknowledgment of Cancellation & No-show Agreement

_____
Printed Name

_____ Date Signed _____

Signature of Patient

_____

Date Signed