PIEDMONT ~Complex, Chronic Pain
PHYSICAL MEDICINE ~Physical Medicine and Rehabilitation
& REHABILITATION, P.A. ~Regenerative & Vascular Medicine
317 ST. Francis Drive, #350, Greenville, SC. 29601 P (864)235-1834 Fax: (864)235-2486 piedmontpmr.com
Matthew Terzella, M.D. ***Robert G. Schwartz, M.D.***

CONSENT/AUTHORIZATION TO RELEASE PROTECTED MEDICAL INFORMATION FROM THRID PARTIES

PATIENT NAME: _____
LAST FIRST INITIAL

SOCIAL SECURITY NUMBER: _____---_____---_____ DOB: ____/____/_____

ADDRESS: _____
STREET CITY STATE ZIP

I consent to and authorize Piedmont Physical Medicine and rehabilitation, PA to receive all records/reports from my medical chart (or other protected health information). Please send them via postal or facsimile (PLEASE MAIL IF MORE THEN 10 PAGES) to:

Piedmont Physical Medicine & Rehabilitation, 317 St. Francis Dr. Suite 350 Greenville, SC 29601

I do not give permission to release any information regarding: Substance Abuse _____, HIV_____, or Psychiatric/Mental Health_____.

Time Limit & Right to Revoke Consent/Authorization: Except to the extent that action has already been taken in reliance on this authorization, I understand that at any time I can revoke this authorization by submitting a notice on writing to Piedmont Physical Medicine & Rehabilitation, P.A. Unless revoked, this authorization shall be in force (without a time limit).

Re-disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability Act of 1996. Piedmont Physical Medicine & Rehabilitation, P.A., its employees, officers, and physicians are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

_____

Patient's Signature **Date**

_____

Witness Signature **Date**

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CONSENT/AUTHORIZATION TO RELEASE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS/PRACTICE PRIVACY POLICY ACKNOWLEDGEMENT/MEDICAL SERVICES WAIVER/PATIENT RESPONSIBILITY FOR CHARGES/LETTER OF PROTECTION

1. **Consent/Authorization to Release Information:** I hereby authorize Piedmont Physical Medicine & Rehabilitation (PPM&R) to release any information regarding my treatment to all payers to facilitate payment on pending claims and I consent to PPM&R's use and disclosure to protected health information about me, for treatment, payment, and health care operations in accordance with the HIPAA Law. I hereby consent/authorize and direct all payers to release to PPM&R any information regarding coverage or benefits that I may have, including, but not limited to, the amount of the coverage, the amount(s) paid thus far, and the amount of any outstanding claims.
2. **Acknowledgement of Practice Privacy Policy:** I acknowledge notice of PPMR's Practice Privacy Policy as required by the HIPAA law.
3. **Medical Services Coverage Waiver:** I hereby authorize PPM&R to perform any medical services that they may offer. While PPM&R will try to inform me in advance of any possible non-covered insurance issues, in the event that my carrier determines that it will either not pay, or grossly under pay for services rendered, then this document will act as a private contract for the delivery of medical services rendered. I further agree and consent to pay PPM&R any dollar amount that my third-party payer withholds or offsets from PPM&R, or denies payment to PPM&R, because of my failure to adhere to the terms of my third-party contract.
4. **Patient Responsibility for Charges:** I am fully aware that I am personally responsible for all charges incurred by me at PPM&R. If PPM&R must take action to collect any outstanding balance on my account, I will be responsible for the payment of those charges and will reimburse PPM&R for all costs of collection, including, but not limited to, normal business expenses, attorney's fees and court costs. I authorize PPM&R to apply my credit balance on charges incurred by me to any other outstanding charges still owed by me, spouse, and my dependents or otherwise. This instrument shall not be modified or revoked without the mutual consent of PPM&R any myself.
5. **I consent/authorize my Spouse, Legal Guardian and/or (print name) _____ to have full access to my protected health information.**
   ***PATIENT NAME*_____*MEDICAL RECORD #*_____**
   ***PATIENT SIGNATURE*_____*DATE*_____**

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I am not a Medicare beneficiary, or I have notified PPM&R that I am one so that I may sign a Medicare Opt-out Contract.

Letter Of Direction/Letter of Protection: **Doctor:**

To: Attorney's Name_____ PPM&R, Matthew Terzella, MD Robert G. Schwartz, MD

Attorney's Address_____317 St. Francis Dr. Ste. 350 Greenville, SC 29601

This document authorizes Piedmont Physical Medicine & Rehabilitation (PPM&R) to furnish you, my attorney, with a full report of my case history, examination, diagnosis, etc. regarding the accident, which occurred on_____ This advises you that I am undergoing treatment at PPM&R for injuries sustained in the accident. You may be calling on them for reports and/or testimony. I authorize and direct you to pay PPM&R out of the proceeds of any settlement or collection made by you for my injuries. I direct you to use this letter as a Letter of Protection for PPM&R. I agree that such LOP cannot be revoked or modified without PPM&R's written consent. DATE: _____

WITNESS: _____PATIENT SIGNATURE: _____ATTORNEY SIGNATURE: _____

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Consent to Patient Financial Responsibilities

Thank you for choosing Piedmont Physical Medicine & Rehabilitation, PA. We are honored and committed to providing you with the highest quality of healthcare. We ask that you sign this form to acknowledge your understanding of our patient financial policies.

Each patient is required to provide us with the most correct and updated information about their insurance. As a courtesy we will assist you by billing your insurance if we are contracted with them, including workers compensation claims.

Each patient, however, is still responsible for all charges incurred, even if due to no fault of their own the insurance information provided to us is incorrect or not updated. Each patient (patient's guardian, if a minor) is ultimately responsible for the payment of their treatment and care.

Patients are always responsible for ALL copays, coinsurance, and deductible payments along with any other procedures or treatments not covered by their insurance plans. ***Payment is due at the time of service.*** As a convenience to you we accept cash, check, and most major credit and debit cards.

Patients may incur and will be responsible for additional non-insurance related charges. These charges are at the discretion of Piedmont Physical Medicine & Rehabilitation and include (but are not limited to): Charges for returned checks, charges for form completion, costs associated with the collection of patient balances.

By signing this form, you are acknowledging that you have been notified of your financial responsibilities and that you both consent and agree to them.

Patient Signature: _____Date: _____

Witness: _____

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We here at Piedmont Physical Medicine and Rehabilitation strive for excellence regarding all aspects of care for our patients. Your health and wellness are and will always be our priority.

As you know, the specialty services we offer here are not found at many other offices. We want to continue to be able to provide the care that you have come to expect while you receive treatment with us.

We want to make you aware that many, if not all the insurances we take are now paying less and less for the treatment we offer. We will continue to submit claims to your insurance. However, if they deny your treatment for any reason, you will be responsible for the unpaid amount. This could be anything from denying due to "lack of medical necessity", no authorization on file, service not covered, service is experimental, etc.

As always, we check your benefits beforehand. However, the insurance companies can make their own rules and may pick and choose what they want to pay, not pay, or even take payment back from years past.

We take this very seriously and want to inform you that the quality of care you receive from Piedmont PMR will NOT change regardless of how insurance companies choose to act.

Please, if you have any questions, we will be happy to discuss that with you!

Please sign below to agree that you have read this notice and will be responsible for any claims denied through no fault of Piedmont Physical Medicine and Rehabilitation.

_____ _____

Print Patient Name *Patient Signature*

_____ _____

Witness *Date*

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Agreement to Self-Pay for Services

By signing this agreement, I agree to self-pay Piedmont Physical Medicine & Rehabilitation, PA for services offered or rendered. I understand that payment for any services, including any portions of them, or the supplies associated with them are my personal responsibility, regardless of any third-party insurance that I may have. I understand and agree that these services, or a portion of them, will not be filed with my insurance.

I further understand that Piedmont Physical Medicine & Rehabilitation, PA has expenses associated with offering and providing services. Since I want to have services made available to me, upon request I agree to prepay for any services offered or provided by Piedmont Physical Medicine & Rehabilitation PA. I further understand that any payment for these services is non-refundable, even if I fail to keep my appointments for them.

I also understand that if I later change my mind and request that services rendered be filed under a third-party payment arrangement (such as private health insurance) then Piedmont Physical Medicine & Rehabilitation, PA is under no obligation to do and in fact may not be able to do so.

If however Piedmont Physical Medicine & Rehabilitation, PA does agree to later file either a portion or all of the services rendered to my third party insurance then I understand that I will be responsible to pay an administrative fee to compensate Piedmont Physical Medicine & Rehabilitation, PA for doing so. I also understand that I may have to make additional payments to Piedmont Physical & Rehabilitation, PA to cover all charges that are either not allowed by my insurance company or are paid at a rate less than Piedmont Physical Medicine & Rehabilitation, PA's charges.

In addition, I understand that any additional payment due Piedmont Physical Medicine & Rehabilitation, PA under the terms of this agreement will have to be made to Piedmont Physical Medicine & Rehabilitation, PA prior to filing my charges with my third-party arrangement.

PATIENT SIGNATURE: _____ DATE: ___/_____/_____

WITNESS: _____