YUKON WOUND CARE AND REHABILITATION

CONSENT FOR CARE

I authorize YWCR to furnish my insurance company or its representative, any information requested for claims or billing purposes. I authorize payment for these services directly to YWCR for all charges. I will be responsible for all charges, whether covered or not, by my insurance. YWCR or its billing service may check credit with a source to obtain credit information. I authorize any holder of my medical information to release the information needed for my care or to determine benefits payable for related services. This release may include information which could be considered a communicable disease such as hepatitis, syphilis, gonorrhea and/or human immunodeficiency virus HIV/AIDS. I consent to all tests, treatments and procedures provided by YWCR. I grant the requested authorizations and the information I have provided is accurate to the best of my knowledge.

CANCELLATION / NO-SHOW POLICY

All *routine* cancellations need to be done at least 24 hours in advance. There will be a $20 charge for all No-Show / No-Call appointments. If you will be late or must cancel due to *emergency* circumstances, please contact us ASAP. If you will be more than 15 minutes late for an appointment, it may need to be rescheduled.

INJURY OR THIRD PARTY LIABILITY / HOME HEALTH

If your therapy is due to an injury where a third party may be liable, you could be responsible for charges at the full-pay rate (subsequent to non-payment by your insurance carrier). If you are receiving home health, your insurance cannot be billed for therapy services; you will be responsible for charges at the self-pay/discounted rate. Please inquire about a Third-Party / Self-Pay Contract if needed.

Co-Pays & Co-Insurance Payments are due at the time of service

My signature below indicates that I have read and understand the above. A photo copy of this authorization shall be considered as valid as the original.

_____**Date:**_____

Signature of Patient / Parent or Guardian