

**AUTHORIZATION FOR TREATMENT / ASSIGNMENT OF BENEFITS / PAYMENT
RESPONSIBILITY AND RELEASE OF INFORMATION**

Patient Name: _____

Address: _____

Provider: **Magnolia Rehab Services, Inc.**

Authorization for Treatment: The undersigned hereby authorizes Magnolia Rehab Services, Inc. and / or any of their contractors (collectively referred to as "Provider"), to render to patient physical therapy, occupational therapy, speech therapy, audiology, psychological services or other related services (collectively referred to as "Therapy Services") that Provider and / or patient's physician determine to be necessary and advisable. The undersigned agree to cooperate with all reasonable requests of Provider in connection with Provider's rendering of Therapy Services.

Assignment of Benefits: The undersigned hereby assign and transfer to Provider the right to all third party payments (including Medicaid, or/or private insurance benefits) to which the undersigned may be or become entitled to for Therapy Services rendered by the Provider. The undersigned hereby authorizes Provider to apply and file for all such benefit payments on behalf of the patient and direct that such payments be made directly to the Provider. Any insurance benefit payments received by the undersigned for services rendered by the Provider shall be paid to the Provider.

Payment Responsibility: The patient shall be financially responsible for any portion of the Provider's invoice that is not paid, except in the event of covered services provided to Medicaid recipients. The undersigned agrees to execute any and all documents and perform any acts that Provider may reasonably request to ensure that all third party benefits for Therapy Services are paid to Provider.

Release Information: The undersigned hereby certifies that all information provided to Provider by the undersigned is true and accurate in all respects. The undersigned hereby authorizes Provider to disclose any information, medical and non-medical, furnished to or obtained by Provider in connection with Patient's diagnosis and / or treatment, to any physician, government agency (including the U.S. Department of Health and Human Services, or any of its intermediaries or carriers), insurance company or health care provider requesting such information. The undersigned agrees to allow Provider access to Patient's medical records and agrees to allow Provider to make copies of such records. The undersigned consents to the discussing by Provider of the patient's medical condition with patient's family members for medical or claims management purposes.

Executed this _____ day of _____, 20____.

Patient's Representative Signature (specify relationship)

Witness