AGREEMENT FOR THE ESTABLISHMENT OF OUTPATIENT SERVICES

I hereby give my permission for authorized personnel to perform all necessary procedures and treatments as prescribed by my physician for the delivery of outpatient services. I understand that there may be circumstances beyond the control of the Facility when there may be short interruptions in service. During these interruptions I will contact my family physician if I determine I need care. I also understand that the hours of service may change by mutual consent between the patient, or responsible party, and the Facility**.**

Saguaro Rehabilitation is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. **Please call us at (480) 982-7794 by 2:00pm on the day prior to your scheduled appointment to notify us of changes. To change a Monday appointment, please call our office by 2:00pm on Friday. If prior notification is not given, I understand I will be charged $25.00 for the missed appointment. Multiple consecutive cancellations and/or no shows will result in their being removed from service.** (initial)_____

I acknowledge that I have read and understand the Saguaro Rehabilitation's Patient Bill of Rights Policies and the Appointment Cancellation Policy and can request my own copy. I hereby give my permission to release to or receive from hospitals, physicians, or other agencies involved in my care, the medical records and information pertinent to my care. I understand that my health information will only be used for the purposes of treatment, payment, and health care operations, as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I request that payment of authorized benefits be made on my behalf to Saguaro Rehabilitation and Aquatic Therapy, LLC.

Signature of Patient or Authorized Representative: _____

If other than patient, state relationship and authority to sign: _____

Date:_____

For Medicare Patients Only

Authorization to Release Information and Payment Request

I certify that the information given by me applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf to Saguaro Rehabilitation and Aquatic Therapy, LLC.

Signature of Patient or Authorized Representative: _____

If other than patient, state relationship and authority to sign: _____

Date:_____

Emergency Contact Information

Contact Person: _____Relationship:_____Phone: _____

Hospital Preference: _____

Returning Patients Only – No changes to my address or phone

Signature of Patient or Authorized Representative:_____

Witness Signature: _____ Date: _____