Everest Rehabilitation Services

For All Patients

Release of information & Consent for Care and Treatment

I ________________________________ (Last name, First name) certify that I, and/or my dependent (s), have insurance coverage and have assigned directly to Everest Rehabilitation Services, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I authorize the release of medical information, relative to treatment received, to the insurance company for payment of these services as Everest Rehabilitation Services, LLC may use my health care information and may disclose such information for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I, the undersigned , do hereby agree and give my consent for Everest Rehabilitation Services to furnish skilled medical care and treatment to ______________________________ (Last name, First name), which is medically necessary and proper in the diagnosing and treating of my/his/her physical condition.

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Signature of Patient/ Parent/ Guardian Date

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Print Name (Last, First) of Parent/Guardian