TEXAS STAR
REHAB AND PERFORMANCE CENTER

Patient Consent Form

__________I consent to **evaluation and treatment** by Texas Star Rehab and Performance Center and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

__________I have received a copy of Notice of information/ Privacy Practices.

__________I understand that Texas Star Rehab and Performance Center is not responsible for any lost or stolen of my personal property at or in the vicinity of the clinic location. I am fully responsible for that.

__________The filling of insurance claims is a courtesy that we extend to our patients. **You will be responsible for any charges not reimbursed or contractually adjusted by your insurance company.** Should your claims not process as you expected or should you have any questions regarding your insurance plan benefits, please contact your insurance company directly.

__________I authorize the **release of information** acquired in the course of my treatment including by not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, other third party payers and/or the following

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__________Should a patient account become 90 days past due the account will be placed with a collection agency and a $40.00 collection fee will be charged.

__________I authorize phone, e-mail, and/or text messages regarding my treatment and appointments to be left with persons or machines at the phone numbers provided.

__________ I understand that in order to protect the confidentiality of our patients, there can be no filming, going "live" via social media or taking pictures of my treatment, or that of other patients, without prior authorization from the Clinic Director.

__________ I hereby assign to Texas Star Rehab and Performance Center all payment for medical services rendered to myself or my dependents. I **understand I am responsible for any amount not covered by my insurance.**

__________**I understand I will be charged a fee of $30.00 for canceled or missed appointments without 24 hour notice. Payment must be rendered prior to next scheduled visit.**

Print Name (Patient / Guardian) :___________________________

Patient / Guardian signature______________________ Date :___________________________