GALLOWAY RIDGE at Fearrington
Center for Physical Rehabilitation
Duke Center for Living HEALTH AND FITNESS CENTER at Fearrington
50 Craggenmore • Pittsboro, NC 27312 • Phone (919) 545-2633 • Fax (919) 545-2654

Treatment and Release of Information and Financial Notice

Patient Name_____ DOB _____

Authorization for Treatment and Release of Information

I consent and authorize Galloway Ridge D.B.A Duke Center for Living to provide Physical, Occupational and or Speech Therapy set forth as ordered by my physician. Unless treatment would require isolation, I authorize the therapy to be provided in areas not totally isolated from other patients and personnel.

- This authorization or copy of same authorizes the release to Galloway Ridge, D.B.A. Duke Center for Living of any medical information necessary for treatment, processing of claims or insurance appeals for services rendered by Galloway Ridge, D.B.A. Duke Center for Living.
- This authorization authorizes Galloway Ridge, D.B.A. Duke Center for Living to disclose any information furnished by Galloway Ridge, D.B.A. Duke Center of Living or Rehab Care In connection with patient's treatment, insurance, physician, governmental agency or healthcare facility requesting such information.
- Patient and authorized Patient Representative agree to execute any documents and perform any acts that Galloway Ridge, D.B.A. Duke Center for Living may reasonably request with regards to therapy services.
- The undersigned warrants and represents that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of patient.

Assignment of Benefits/Financial Responsibility

- Patient or authorized Patient Representative hereby assigns to Galloway Ridge, D.B.A. Duke Center for Living all medical insurance benefits or other benefits to which patient may be entitled to but not limited to therapy services rendered by Galloway Ridge, D.B.A. Duke Center for Living.
- Patient or authorized Patient Representative authorizes and directs Galloway Ridge, D.B.A. Duke Center for Living to and represents the patient during the appeals process in the event of a denial of any insurance or Medicare benefits.
- Patient or authorized Patient Representative agrees that he or she is financially responsible for any portion of Galloway Ridge, D.B.A. Duke Center for Living's invoice that is not paid, including but not limited to deductible, co-insurance, copayments. Any non-insured or non-covered services authorized or not authorized and any charges in excess of insurance payment limitations imposed by third party payers except in the event of Medicare denial or not paid directly by said insurance.
- Patient or authorized Patient Representative authorizes and directs Galloway Ridge, D.B.A. Duke Center for Living to represent the patient during the appeals process in the event of a denial of Medicare benefits or any insurance denial.

Release of Information/Terms

I hereby consent and acknowledge receipt of Notice of Privacy Practices to use and disclosure of my personal information for purposes as noted in Galloway Ridge, D.B.A. Duke Center for Living Notice of Privacy Practices. A copy of this consent shall be considered as effective and valid as the original. I understand that I retain the right to revoke this consent by notifying Galloway Ridge, D.B.A. Duke Center for Living in writing at any time.

Signature of Patient _____Date _____

Signature of authorized Patient Representative (if applicable)_____Date_____

Name_____Relationship to Patient_____

Witness Signature_____Print Name_____Date_____