UCONN
NAYDEN REHABILITATION CLINIC

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CONDITIONS OF CARE

We thank you for choosing Nayden Rehabilitation Clinic for your health care needs and assure you that we will do our best to meet your expectations. Please read and sign the sections printed below.

Consent for Treatment: I give my consent for evaluation and treatment by the Nayden Rehabilitation Clinic. Though I expect the care I receive will meet my expectations, I do understand that rehabilitation is not an exact science, and I acknowledge that no guarantees have been made as the result of such treatment or examination. If I refuse treatment that is suggested for me, I will not hold the University of Connecticut, Nayden Rehabilitation Clinic or any individual responsible for any consequences resulting from my decision.

Please note: The Nayden Rehabilitation Clinic is a teaching facility. If you would prefer students not be present during your treatment, please discuss this with your physical therapist.

Assignment of Benefits: I request the payment of authorized benefits to be made on my behalf. I assign the benefits payable by my insurance company to Nayden Rehabilitation Clinic for services provided. I further authorize the named healthcare provider to submit claims to payers on my behalf. I request that this authorization apply to all services pertaining to the current episode of care. I understand and accept financial responsibility for all payment of charges incurred by me not covered by my insurance carrier and/or this agreement. If I am a self-pay patient, I understand that I am entitled to a detailed itemized bill which will be provided to me within 30 days of request. I acknowledge that copayments, deductible and non-covered charges are my sole responsibility, and understand that Nayden has the right to request copayments at the time of service.

Authorization to Release Information: I authorize Nayden Rehabilitation Clinic to provide any information regarding my care to my insurance company, as well as to any utilization and/or quality review organization affiliated with my insurer for use in utilization management. I further authorize Nayden Rehabilitation Clinic to provide pertinent medical information to other physicians, health agencies and other facilities involved in my continuing care after discharge.

_____ _____

Signature of Patient or Responsible Person **Date**

HIPAA Privacy Act: I understand that should I so choose, I am entitled to a copy of Nayden Rehabilitation Clinic's Notice of Privacy Practices that describes how medical information about me may be used and disclosed and how I can access this information. I understand that if I have questions or comments I may discuss them with an authorized representative of the University of Connecticut.

May we leave a message on the voice mail of the phone number provided: ☐ YES / ☐ NO

May we send correspondence to the email and/or home address provided: ☐ YES / ☐ NO

Is there any anyone other than yourself to whom you authorize us to discuss your care: ☐ YES / ☐ NO

*If YES, whom:*_____ *Relationship to Patient:* _____

_____ _____ _____

PRINT Name **Signature of Patient or Responsible Person** **Date**

Revised 01/14