# PERFORMANCE PLUS
REHABILITATION CENTER

Patient Name: _____

Primary Care Provider: _____

I am allowing Performance Plus Rehabilitation Center, correspond with my medical doctor in regards to my condition and treatment plan.

Signed: _____

Date: _____



P.O. Box 6423 ■ 1802 North Woodbine ■ St. Joseph, MO 64506 ■ 816-232-5113

# Performance Plus Rehabilitation Center
## Consent to Release Information

I, _____, authorize the Pain Management Rehabilitation's staff to discuss my medical treatment and any billing issues with the following people: (Please list any family members, friends, or legal counsel that are allowed to discuss your treatment or billing issues with.)

_____Relation:_____

_____Relation:_____

_____Relation:_____

Date:_____Patient's Signature:_____

## Consent for Imaging

I understand that photographs and videos may be taken during clinic visits and that they may be viewed by various personnel. I consent to the taking and hard copy and electronic storage of such imaging.

Date:_____Patient's Signature:_____

**Performance Plus Rehabilitation Center**
**1802 N. Woodbine, St. Joseph, Missouri, 64506**
**(816) 232-5113 office (816) 232-0453 fax**
**www.performanceplusrehab.com**

# Performance Plus Rehab Center

1802 N Woodbine, Saint Joseph, MO. 64506 816-232-5113, Fax#:232-0453

Thank you for choosing Performance Plus Rehabilitation Center

## Financial Policy:

**Insurance Benefits – Payment Terms and Conditions:**

1) As a courtesy to you, our facility will obtain a verification of applicable insurance benefits as they are quoted to us by a representative or in some cases faxed. **This is not a "guarantee of payment"**. Occasionally a representative may misquote benefits, coverage and liability. Our facility & staff are not responsible for what a representative may tell us or how your insurance ultimately processes the claim.

2) All deductibles must be paid at the time of service. As a courtesy to you, we will allow you to pay co-pays and co-insurance at the end of your treatment week.

3) If insurance pays different than what we expected you may either owe more or be due a refund from our office.

4) Uncovered charges must be paid at the time of service. (electrode pads, therabands, shoulder pulley, balls, pillows or any other supply)

5) If you receive any correspondence from your insurance company pertaining to your care in our office please respond immediately. They will not pay your bill until you respond.

6) If a statement is not paid within the 30 days term a 1.5% interest charge will accrue each month.

7) We reserve the right to discontinue care if 3 consecutive appointments are missed, and/or your balance is not paid.

I have read and understand the financial agreement

Sign/Date: _____