PHENOMENAL REHABILITATION

ADMISSION CONSENT AND AUTHORIZATION

1. Consent for Treatment

I hereby agree to the performance of such procedures and treatments that in the opinion of my treating Phenomenal Rehabilitation therapist deems necessary.

2. Consent to Release Medical Records to Other Providers

I consent to the release of information about my medical condition to any health care provider currently involved in my treatment.

3. Acknowledgement of Receipt of Notice of Privacy Practices

Phenomenal Rehabilitation reserves the right to modify the privacy practices outlined in the notice.

X _____My initials indicate I have received a copy of the Notice of Privacy Practices for Phenomenal Rehabilitation.

4. Assignment of Insurance Benefits and Guarantee of Account

I request that payment of authorized health insurance, Medicare, and /or Medicaid benefits be made on my behalf to Phenomenal Rehabilitation, or to me in the case of non-assigned Medicare claims for any services furnished to me by that clinic. I authorize payment directly to Phenomenal Rehabilitation of insurance, Medicare and/or Medicaid benefits, or other funds the patient or I, the undersigned, are entitled to receive from other sources for payment of services provided to the patient. I authorize Phenomenal Rehabilitation to release all health information about me to Medicare, Medicaid, third-party carriers, health service plan corporations, or health maintenance organizations listed on the Admission Record, and/or third party administrators, to determine payment of my Phenomenal Rehabilitation bill, payment of claims, fraud investigation, and/or quality of care review studies.

For services provided by Phenomenal Rehabilitation to the patient, I the undersigned personally guarantee payment of the bill to Phenomenal Rehabilitation incurred as a result of this health care service. This includes services, which for any reason are not paid by insurance, government programs, or other third-party sources. I shall, within thirty (30) days from the date of each billing statement, pay Phenomenal Rehabilitation the total balance thereon or the minimum periodic payment. The minimum periodic payment required is the greater of $25 or fifty percent (50%) of the entire unpaid balance of the account. If there is a failure to pay any minimum periodic payment when due, Phenomenal Rehabilitation may declare the entire balance due and payable and/or terminate any further extension of credit.

I will pay no Finance Charge on the new balance shown on the monthly statement if such new balance (less any credit issued) is paid in full within thirty (30) days after the date of the monthly statement. I agree to pay a Finance Charge at a rate of twelve percent (12%) per year on the balance of the account at the end of the monthly billing cycle, or a minimum Finance Charge of three dollars ($3.00) per month. Patients may, at any time, pay the full amount.

I agree to guarantee payment to Phenomenal Rehabilitation for alls costs incurred by Creditor in collecting payment, including but not limited to legal costs such as attorney fees, costs and fees, and service fees. I also understand that 12% interest per year may be added if the account balance goes to a collection agency.

I release such information about me and services rendered to me as is reasonably necessary to accomplish the collection of Phenomenal Rehabilitation's bill as a result of this health care service.

This consent and authorization is to remain in effect until I choose to revoke it in writing. I have also had an opportunity to ask questions about the content of this form, and by signing below I agree to the above terms.

X _____ _____

(Patient, Legal Representative, or Guarantor signature - if underage or patient unable to sign) (Date Signed)

_____ _____

(Patient's Personal Social Security Number) (Patient date of Birth)

_____ _____

Name of Patient (Print or Type) Relationship of Patient Representative to Patient