COVENANT HOLISTIC THERAPY

www.covenanthhs.com / contact@covenanthhs.com / (630) 226-5699 / P.O. Box 127 Plainfield, IL 60544

THERAPY CONSENT

1. ACCEPTANCE OF SERVICE

I understand that by signing this two year agreement, I authorize provision of products and/or service provided by Covenant Holistic Healthcare Services, Inc. are prescribed by my physician and that it is necessary that I remain in the care of my attending physician during the course of my therapy.

2. RELEASE OF MEDICAL / INSURANCE INFORMATION AUTHORIZATION

I hereby authorize release to Covenant Holistic Healthcare Services, Inc. all of my medical records pertaining to my medical history, services rendered to me, or treatments received from my Physician (s) or hospitals. In order to process insurance claims, I also hereby authorize Covenant Holistic Healthcare Services, Inc. to furnish my insurance carriers all information which said insurance company may request concerning treatment for myself.

3. MEDICARE

The undersigned certifies that information given in applying for payment under Title XVIII of the Social Security Act and/or Title XIX, is correct and authorized the release of all records required to act on this request so that payment of authorized benefits be made on his/her behalf.

4. MEDICADE

The undersigned accepts the service of Covenant Holistic Healthcare Services, Inc. rehabilitation services, as authorized by the Medicaid Field Office Station.

Medicaid #:_____

5. PRIVATE

The undersigned agrees, whether to sign as an agent or as patient, that in consideration of services to be rendered to the patient, does hereby individually obligate himself/herself to pay the account of Covenant Holistic Healthcare Services, Inc.

Your Insurance Company_____

SERVICES REQUESTED FOR:_____
(Patient Name)

Physical Therapy_____

Occupational Therapy_____

Speech Therapy_____

PATIENT SIGNATURE:_____

FACILITY NAME:_____