RIVERDALE
1807 Highway 138 SW
Riverdale, GA 30296
(770) 997-7000
Fax: (770) 996-0497

ABSOLUTE HEALTHCARE & REHAB CENTER

MCDONOUGH
902 Pavilion Court
McDonough, GA 30253
(678) 583-9583
Fax: (678) 583-1083

RELEASE OF AUTHORIZATION, DIRECTION TO PAY AND FINANCIAL RESPONSIBILITY AGREEMENT

I, _____, hereby authorize this office to furnish my attorney, _____, and/or _____ Insurance Company, or the designee of either, any medical information requested concerning the condition or treatment of injuries sustained by me or my children, on _____.

I authorize and direct the third party liability carrier and/or my attorney, to furnish, directly to this office, a separate check, for the full balance, for all professional services rendered. I further authorize any third party liability carrier and/or my attorney, to disclose the settlement status, settlement statement and/or a copy of the settlement check if requested.

I understand that this in no way relieves me of my personal primary responsibility to pay my doctor for professional services (including any expert witness fee) when a statement is rendered and that I will receive customary billing for said services. I agree that this office is given a Power of Attorney to either endorse or sign any and all checks presented to them for payment of my medical bill with or without direct notification to me.

I understand that I am being treated for injuries sustained in an accident. Because of the laws governing treatment in cases such as mine, the treatment plan, which has been recommended in my case, must be strictly adhered to. I understand that **failure to keep my appointments, without a reasonable excuse, may lead to dismissal** from treatment and may jeopardize future treatment and/or benefits such as the insurance carriers responsibility for medical costs and/or compensation for pain and suffering. **Dismissal or if I discontinue care my full balance will be due immediately**.

I further understand that I will be treated until I have reached a maximum of improvement at which time I will be released from treatment resulting from the injuries sustained in the accident. This is not meant to imply that I will not need further treatment but only that the injuries sustained in the accident have reached maximum improvement.

Once released from care, I will keep in contact with the office manager as to the status of my case.

☐ I am **not being represented** by an attorney: I agree that, **upon settlement, full balance is due immediately**. If **after sixty** (60) days of reaching maximum improvement, no settlement has been made, I will begin making **$100.00 per month** payments. I further acknowledge that if **after 180 days**, from my release date, no settlement has been reached my **full balance may be due immediately**.

☐If I **cease being represented** by an attorney, for any reason, or if you are **unable to contact** my attorney: my **full balance may be due immediately**

I hereby acknowledge that should the net recovery not be sufficient to pay in full all amounts due this office with respect to the above stated matter, then I shall remain personally responsible for any unpaid balance.

_____ _____
Patient Signature Date Witness Signature Date

_____ _____
Patient Name Witness Name