FINANCIAL AGREEMENT

I, the undersigned, agree to pay for services rendered. The account is to be paid in full within 90 days of the date of service. Any amount not covered by my insurance carrier will become my responsibility. I agree to notify my insurance carrier prior to any admission or outpatient procedure. It will be my responsibility to obtain a second opinion, prior approval or pre-admission certification, as deemed necessary by my insurance carrier. I understand that if these requirements are not met, the insurance payment will be reduced and I will be responsible for payment of this amount. I authorize Brooklyn Community Estate (d.b.a. Bear Creek Rehab) to disclose to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, and/or my insurance company listed above, any information relating to the identity, diagnosis, prognosis, or treatment of the patient named above. I understand that the purpose of this disclosure is to facilitate the payment of insurance benefits.

I request payment of authorized benefits be made to Brooklyn Community Estate and authorize the holder of medical information about me to release to my insurance provider any information needed to determine benefits payable for services.

In consideration for services rendered, I hereby assign to Brooklyn Community Estate benefits to which I am entitled under the terms of my insurance policy(ies) listed above and agree to be responsible for services not paid in whole or in part by my insurance company, which I hereby certify is in full force and effect. This authorization will remain in force and effect until revoked by me in writing.

CONSENT FOR TREATMENT AND RELEASE FROM RESPONSIBILITY

I, the undersigned, being informed that I am or may be suffering from a condition which requires medical services, diagnosis, and or surgical treatment, do voluntarily consent to and authorize any therapy services or treatments that are deemed necessary by my physician or therapy provider. I acknowledge that no guarantees have been made to me or anyone else on my behalf as to the results of such services and procedures.

RELEASE OF INFORMATION

Brooklyn Community Estate (d.b.a Bear Creek Rehab) may disclose all or part of the patient's medical record, pertinent information, or any opinion concerning the patient's medical condition and treatment as requested or required by the patient's insurance carrier, health maintenance organization, worker's compensation, Medicare, self-insured organizations, utilization review or managed care organizations. Brooklyn Community Estate has my permission to release information to an insurance company as the patient applies for new insurance.

RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION

I, the undersigned, understand that I am giving my permission to staff of Brooklyn Community Estate to release **Confidential Medical Information**. This may include but is not limited to information such as appointment or referral times, treatment results, as well as other confidential information. I understand that if I have agreed this **Confidential Medical Information** may be left with those persons listed above. I understand that any information regarding Mental Health, Psychiatric Care, Treatment for alcohol and/or drug abuse or HIV and AIDS will not be released to anyone other than myself without specified authorization. I also understand that my **Confidential Medical Information** may be shared with other healthcare facilities should I require referral services.

DATE: _____ SIGNATURE: _____

LEGAL GUARDIAN SIGNATURE: _____ RELATIONSHIP: _____