MID-ATLANTIC
BRAIN & NEUROLOGICAL
REHABILITATION

Consent for Services

I hereby request and consent to all procedures including various modes of physical therapy, diagnostic testing, and/or any other such aspects of treatment by Mid-Atlantic Brain and Neurological Rehabilitation (MABNR) and their staff who now, or in the future treat me while employed by this office. I have had the opportunity to discuss with Dr. Lane/Dr. Jackson and/or with other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of healthcare, there are some risks to treatment including but not limited to seizures, ischemic events, fractures, disk injuries, strokes, dislocations, and strain/sprains. I do not expect the doctor to be able to anticipate or explain all risks and complications, and will rely on the doctor to exercise judgment during any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me the full above consent and have also had the opportunity to ask questions about its content, and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic and/or employed staff.

Initials: _____

I understand and agree that the health and accident insurance policies are an arrangement made between the insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to pay directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible both for payments and knowledge of my insurance policy. Mid – Atlantic Brain and Neurological Rehabilitation (MABNR) is not responsible for such information and will assume no responsibility for monies owed due to insurance cessation. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered to me will be immediately due and payable.

Initials: _____

_____
Patient Name (Printed)

_____
Signed

_____
Date