CONSENT TO TREATMENT AND AUTHORIZATIONS

CONSENT TO TREATMENT: The patient and /or authorized representative of the patient, whose signature is affixed below, does hereby consent to any and all medical treatments and diagnostic examinations administered at or offered in association with the operations of ***Osteopathic Family Wellness Center*** which treatments/examinations may be deemed advisable by my/the patient's physician to diagnose and/or treat me/the patient during the period I/ the patient am accepted as a patient of ***Osteopathic Family Wellness Center***.

AUTHORIZATION FOR RELEASE OF CONDIDENTIAL INFORMATION: I hereby authorize ***Osteopathic Family Wellness Center*** and ***April Smith-Gonzalez, DO*** to release medical, psychiatric, and substance abuse information, whether contained now or in the future, in my/the patient's records to the following: insurance carrier(s) and/or employee(s) and/or organization(s), or corporation(s) for the limited purpose of obtaining payment of all or part of ***Osteopathic Family Wellness Center*** charges for medical care rendered, including professional fees including financial and medical record information to substantiate the need for the medical care rendered and the cost associated with medical charges incurred.

The federal HIPAA Privacy Regulations authorize health care providers to share your medical information for treatment purposes, without your consent, including treatment received after you leave the hospital. Florida Law, however, restricts (in some instances) the ability of the hospital to share your medical information with health care providers for treatment purposes, if treatment is sought after your discharge. By signing this consent, you authorize the release of your records (current and historical) to health care providers with whom you or your treating physician(s) may consult for medical treatment. **If you do not want to consent, you must cross through this paragraph and place your initials in the margin next to the paragraph**. If you want an entity or person to receive information regarding your medical records, please fill out the Release of Records Form. (Front Desk will have this form.)

This consent will remain in force during the period that I/the patient is accepted as a patient of ***Osteopathic Family Wellness Center***. You may revoke this authorization at any time by notifying ***Osteopathic Family Wellness Center*** in writing, however, your revocation will not affect any action taken by ***Osteopathic Family Wellness Center*** prior to receipt of notice of your revocation and the Practice has a reasonable opportunity to act upon the revocation.

Information disclosed pursuant to your authorization if from records whose confidentially is protected by Federal of State law. Federal regulations of State law prohibit making any further disclosure of HIV antibody/substance abuse information without the specific written consent of the person to whom it pertains, or as otherwise permitted by the Federal/State Law.

FINANCIAL RESPONSIBILITY (Insured): In consideration of the services I will receive during my treatment and / or any subsequent related treatments including any outpatient ***Osteopathic Family Wellness Center*** visits. I hereby obligate myself to ***Osteopathic Family Wellness Center*** physicians and agree to pay for all Co-payments, Co-insurances, or Deductible charges, expenses and fees incurred or to be incurred in relation to the provision of services. I understand that no credit is being extended to me and that ***Osteopathic Family Wellness Center*** account for services is immediately due and payable in the office at time of service.

IF I DO NOT HAVE INSURANCE: I understand that paying ***Osteopathic Family Wellness Center*** bills for the account is my responsibility. Except for services required to be provided by law, I understand that ***Osteopathic Family Wellness Center*** reserves the right to require proof of my ability to pay and may require a deposit or payment in full before treatments. Any deposits shall be applied to my account.

I certify that the medical and financial information I will provide in connection with my treatment at ***Osteopathic Family Wellness Center*** is true, complete and accurate in every respect.

ASSIGNMENT OF INSURANCE BENEFITS: I assign payment directly to ***Osteopathic Family Wellness Center.*** All insurance benefits otherwise payable to me for medical treatment rendered by ***Osteopathic Family Wellness Center*** will be paid to ***Osteopathic Family Wellness Center*** by myself/the patient. I understand I am financially responsible for charges not paid by this assignment, and that I/the patient will assist in the collection of my /the patient's insurance should there be any delay in payment. **If my/the patient's insurance payment has not been received by *Osteopathic Family Wellness Center* within 30 days of claim receipt, I /the patient agrees to actively and vigorously pursue collecting the insurance payment. If my / the patient's insurance has not remitted charges due within 45 days of receipt of claim, I understand the entire balance becomes due and that *Osteopathic Family Wellness Center* may seek payment direct from me/the patient. THIS ASSIGNMENT OF BENEFITS IS IRREVOCABLE.** Returned checks are subject to redeposit without further notice. State authorized returned check fees will be assessed and will be debited from your checking account without further notice, along with the amount of the returned check plus our $35.00 return check fee.

MEDICARE, MEDICAID OR OTHER KINDS OF GOVERNMENT INSURANCE: I request that payment of authorized Medicare, Medicaid or other kinds of Government Insurance benefits be made on my/the patient's behalf to ***Osteopathic Family Wellness Center***. You authorize any holder of medical information about me /the patient to release to the Center for Medicare & Medicaid Services and its agents, any information needed to determine benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If Item 9 of the HCFA-1500 claim is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the

Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge authorized by the Medicare Carrier.

INSURANCE RECORD OF UNDERSTANDING: If I have private insurance, I agree to be responsible for co-payments, co-insurance, and deductible amounts required by health insurance plans. Your insurance company may require pre-authorization (precert), usually through your physician, to determine for which service(s) they will pay. Your insurance company may not pay your claim or may reduce your benefits if you do not provide us with a proper authorization. After the pre-authorization is obtained, additional information may be required by your insurance company for each visit to be covered. I understand that if I do not obtain the proper authorization. I will personally be liable to pay any penalty up to the total amount charged for the services received.

PATIENT/GUARANTOR AGREEMENT: I/we understand that ***Osteopathic Family Wellness Center*** is not in the business of extending credit and, therefore, the policy requires **PAYMENT IN FULL AT THE TIME TREATMENT IS RENDERED.** If the practice must use the services of a collection agency or a service to encourage prompt payment, a collection charge will apply. We also will provide you with notice that you are being discharged as a patient. Medical records will then be subject to a charge to transfer them to another practice (If you are discharged from our practice).

NOTICE TO GUARANTOR: Do not sign this contract before you read it or if it contains any blank spaces. You are entitled to an exact copy of the agreement you sign. The undersigned hereby acknowledges receipt of a copy of the above disclosure statement containing all information pertinent to this transaction. By signing this patient/guarantor agreement, the guarantor(s) agree(s) to guarantee payment of all charges incurred by the patient for services. This is an absolute guaranty and it shall continue as long as any balance is due. I understand I am financially responsible for my account with ***Osteopathic Family Wellness Center*** regardless of any insurance benefits. (By my signature below, I acknowledge reviewing the information contained in this document.)

_____
PATIENT'S FULL NAME (PLEASE PRINT CLEARLY)

_____	_____	_____
PATIENT SIGNATURE	**STAFF WITNESS**	**DATE**
_____	_____	_____
OTHER REPRESENTATIVE (parent)	**STAFF WITNESS**	**DATE**

By signing this portion of the form, I acknowledge that I have received and read a copy of *Osteopathic Family Wellness Center's* Notice of Patient Privacy Practices (NPPP) which described the permitted uses and disclosure of my health care information related to my care by *Osteopathic Family Wellness Center,* and payment of my charges for the services received. I consent to the uses and disclosures of my health care information described in *Osteopathic Family Wellness Center's* NPPP.

_____	_____	_____
PATIENT SIGNATURE	**STAFF WITNESS**	**DATE**
_____	_____	_____
OTHER REPRESENTATIVE (parent)	**STAFF WITNESS**	**DATE**