Consent and Conditions for Treatment

Consent: I hereby authorize **The Geraldine Clinic, LLC** and/or their staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by our providers to make a thorough diagnosis of my/my charge's health needs. Upon such diagnosis, I authorize **The Geraldine Clinic, LLC** to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care. I agree to use all medications prescribed to me as directed.

I understand, acknowledge, and agree that photographs and images of me may be shown to other patients, potential patients and doctors for treatment and educational purposes. I further understand that my name or identifying information will be kept confidential.

Financial Information: As a courtesy, this office will help prepare and submit your insurance forms, however I understand that any fees not covered by insurance are my final responsibility. By signing this form I authorize this office to submit insurance claims and to contact my insurance company on my behalf. In consideration for the professional services rendered to me or at my request, I agree to pay for all services regardless of insurance coverage.

I understand that any fee estimate provided by this office for my health care is only extended for a period of ninety (90) days from the date of the patient examination.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment. I understand that in the event that I default in the payment of feed due to **The Geraldine Clinic, LLC**, I will be responsible for all expenses incurred by **The Geraldine Clinic, LLC** including, but not limited to attorney fees, collection expenses, discretionary costs and court costs associated with collecting outstanding fees. I also understand that negative payment information may be reports to credit agencies.

HIPPA information: I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment(including direct or indirect treatment by other healthcare providers involved in my treatment): obtaining payment from third party payers (e/g/ my insurance company): the day-to-day healthcare operations of you practice. I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care options, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their continent.

Patient or Authorized Person: _____

Date: _____ Relationship to Patient:_____