Optimal Care & Wellness

Authorization for Treatment; Release of Health Information; Assignment of Benefits

CONSENT FOR MEDICAL TREATMENT / PROCEDURE

____ I give consent for my provider at Optimal Care and Wellness to carry out any treatments, procedures, anesthetics, or operations that he or she determines are appropriate or required for my diagnosis and care. I am aware that practicing medicine and having surgery is not a precise science, and I acknowledge that the provider has not given any assurances or warranties whatsoever. In the event that a healthcare professional comes into contact with my blood or bodily fluids by mistake, I give permission and consent to having a sample of my blood tested for certain infectious diseases, such as hepatitis and the AIDS virus. I am aware that if certain tests are carried out as a result of exposure to a healthcare professional, I will not be charged for them. I understand the significance of such testing for both my own benefit and for healthcare personnel.

AUTHORIZATION FOR RELEASE OF INFORMATION

____ The provider is permitted to provide requested information or excerpts from the patient's medical record to the primary care or referring physician, if applicable, as well as to any insurance company or third-party payor in order to obtain reimbursement for the patient's care. To any healthcare facility or provider assisting with the continuum of my care, the provider is permitted to distribute information from my medical records.

ASSIGNMENT OF INSURANCE BENEFITS

____ If the patient is eligible for medical benefits through an insurance policy protecting them or another person responsible for them, those benefits are hereby allocated to the provider for inclusion on the patient's bill. Patient gives authorization for payment of insurance benefits to be paid directly to Optimal Care and Wellness, including any assisting medical professionals or billing agents. Charges not covered by this assignment of insurance benefits are the patient’s responsibility.

FINANCIAL RESPONSIBILITY

_____I accept, as the patient or the responsible party, the obligation to pay all fees incurred by the provider in connection with the patient`s treatment or expenses associated therewith in exchange for the services to be provided to the patient. The undersigned shall be responsible for paying the actual charges billed. Any prices that were anticipated at the time of treatment are liable to change.

CONSENT FOR PHOTOGRAPH TO BE TAKEN

____ I give Optimal Care and Wellness my consent to release my medical records to my primary care provider, my referring doctor, and my insurance company for the purpose of processing a claim, and any other entity I may authorize in the future, including my picture, if the provider determines that it is appropriate to do so.

_____ _____

Printed Name of patient, Authorized Representative or Responsible Party Date

_____ _____

Signature of patient, Authorized Representative or Responsible Party Date