Consent to Treat and Health Care Agreement for Empowered Health

1. Consent to Treat

I hereby consent to evaluation, diagnostic procedures, testing, and treatment as directed my physician or his/her designee. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care.

I understand that this Consent to Treat will be valid for each visit I make to the Empowered Health until revoked by me in writing.

2. Consent to Release Information

I acknowledge that Empowered Health may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that Empowered Health's Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS.

I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure, I may be required to pay the entire cost of medical care provided by Empowered Health.

I acknowledge and consent to allow Empowered Health to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may "opt out" and not have my protected health information disclosed through health information exchange systems by providing the signed Seton "opt-out" form to the practice location where I receive treatment.

3. Assignment of Insurance Benefits/Patient Financial Responsibility

I assign and transfer to Empowered Health all rights, title and interest in payments from third-party payors, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that Empowered Health are unable to collect from my third-party payor for

whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys' or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorney's fees and collection expenses.

4. Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Empowered Health on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

5. Lab/X-ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services that are not provided by Empowered Health or its employees. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payer for whatever reason.

6. Consent to Photograph/Digital Imaging

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that Empowered Health will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

7. Notice of Privacy Practice

I acknowledge receipt of the "Notice of Privacy Practices" from Empowered Health.

Patient Printed Name **Patient Signature**

_____ _____

Patient Date of Birth

_____

Patient/Responsible Party Printed Name **Patient/Responsible Party Signature**

_____ _____

Witness Printed Name **Signature of Witness**

_____ _____

Date

_____