~Nearla Integrated Healthcare Services, LLC

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for **~Dr. Marie Marlene Jean, NP~** to furnish medical care and the treatment to _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party _____ Date _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical beenfits to include major medical benefits to which I am entitled, including Medicare, private insurance and third party payors so **Nearla Integrated Healthcare Services**. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information neccessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party _____ Date _____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for the payment of your estimated share be made today. If your insurance carier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.
If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to **~Nearla Integrated Healthcare Services, LLC~.**

The above may not apply for those patients that are considered Worker's Compensation or who have benefits with a balance billing contract, such as an **HMO**. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

~Nearla Integrated Healthcare Services~ verifies benefits as a courtesy to you. However, we do not accept responsibility for any incorrect information given by you insurance carrier regarding your co-pay/co-insurance benefits or benefit plan.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all cost of collecting monies owed, including court cost, collection agency fees, and attorney fees.

INFORMATION PRIVACY: ~Nearla Integrated Healthcare Services, LLC~. Will use and disclose your personal health information treat you to receive payment for the care provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party _____ **Date** _____

Responsible/Witness _____ **Date** _____