Sendero Medicine, PLLC
Consent for Treatment
Consent for Release of Protected Health Information
Acknowledgement of Receipt of Notice of Privacy Practices
Statement of Financial Responsibility

CONSENT FOR TREATMENT
I consent to evaluation and treatment by the physicians and health care providers of Sendero Medicine, PLLC. I understand that resident physician(s) or other health professionals in training may be part of my care team.

RELEASE OF PROTECTED HEALTH INFORMATION
I give permission to Sendero Medicine, PLLC to release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary to communicate with your other physician(s) or healthcare providers and/or to help procure appropriate payment from my insurance company. By signing below, I acknowledge a complete Notice of Privacy Practices has been made available to me.

ASSIGNMENT OF BENEFITS / STATEMENT OF FINANCIAL RESPONSIBILITY
I hereby authorize and request that payment of benefits by my insurance company or companies be made directly to Sendero Medicine, PLLC for services furnished to me or my dependent. I authorize Sendero Medicine, PLLC to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to Sendero Medicine, PLLC. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

By signing I acknowledge:
1. I am aware and understand that this authorization will not be used unless my insurance company(s) or their designated representatives request my health information to process claims.
2. I agree to participate and assist Sendero Medicine, PLLC or its designated representatives with any appeal process necessary to collect payments for services rendered.
3. A firm contracted by Sendero Medicine, PLLC for billing and collection purposes may do billing.
4. _____ (If applicable) is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan's documents.
5. Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____
(or Authorized Representative)