CONSENT FOR DIAGNOSIS, CARE AND TREATMENT

I consent to and authorize the physicians and other health care providers who may be involved in my care to provide such diagnosis, care and treatment considered necessary for the care I am seeking or as may otherwise be advisable for my well being. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, test, or surgery performed at Complete Health Partners. I authorize the examination, use, storage and disposal of all tissue, fluids, or specimens removed from my body.

NOTICE OF CLOSED CIRCUIT CAMERA USAGE

For safety and security, Complete Health partners uses closed circuit camera surveillance equipment. Closed circuit cameras do not record or detect audio. Cameras are located specifically and only in public areas of the clinic. No cameras are used in any private areas or patient care areas including patients rooms, procedures rooms, X-ray suite, or restrooms. In no way will patient privacy be compromised by camera surveillance.

RESPONSIBILITY FOR PAYMENT / ASSIGNMENT OF BENEFITS / CONTACT

In consideration of the services provided to me by Complete Health Partners, I agree to pay Complete Health for all services and supplies provided to me. If insurance programs cover my treatment, I authorize Complete Health to bill any such insurer for all charges incurred by me in connection with my diagnosis, care and treatment. My insurance coverage may provide that some amount of the bill will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered by my health insurance, Medicare, Medicaid or any other programs for which I am eligible. I understand that certain payments may be required at the time of, or in advance of, services being provided. I also understand I will be billed for any charges not paid by my insurer, and I will be responsible for paying them.

I hereby assign to Complete Health all my rights and claims for reimbursement under any insurance policy for which benefits may be available to pay for the services provided to me, and authorize payment for such service to be made directly to Complete Health Partners.

If I default or do not pay for treatment provided, I acknowledge and agree that Complete Health is entitled to recover the full amount of the debt owed for medical services and is entitled to the right of recovery of all collection expenses, including litigation costs and reasonable attorney's fees incurred for the purpose of securing payment. Collection expenses and/or attorney fees include the fee charged to Complete Health to complete the collection.

COLLECTION AT TIME OF SERVICE

At the conclusion of your visit with Complete Health we will provide you with an estimate of your responsible portion of your bill. This may represent Co-pays, deductibles, and/or co-insurance. This estimated amount is due upon the completion of your visit. After filing the claim with your insurance, you will be responsible for and receive a statement for any remaining amount.

GOVERNMENT COMPLIANCE

In compliance with the Patient Protection and Affordable Care Act and Stark Law, we must inform you that there are other options for obtaining laboratory, diagnostic and radiographic services. It should be noted that you presented to Complete Health voluntarily for your medical care and that as part of that evaluation and treatment it may be determined that particular laboratory, diagnostic or radiographic tests may be needed. It may also be determined that you need referral to specialty care for further treatment or testing. Complete Health offers many of these services as a convenience for our patients. Any patient can elect to have these services provided at a different location and we can provide a list of nearby providers. By Law, we are not allowed to treat any Medicaid patients. It is your Duty to inform us if you have Medicaid.

RELEASE AND USE OF PATIENT INFORMATION

I authorize the release of my medical records, information, treatment, and specific health information to:

1. TREATING PROVIDERS on staff at Complete Health and their staff, agents of other healthcare facilities if direct transfer to that facility is required, and to my primary care provider or any referred consultant for follow up care.
2. INSURANCE COMPANY or other third party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility and benefits, obtaining payment for service rendered, and ensuring government compliance.
3. EDUCATIONAL OR SCIENTIFIC INSTITUTIONS, authorized health care professional students, quality improvement, risk management or legal counsel when it is determined that my medical care, quality improvement, medical education or science will benefit for any purpose authorized by law.
4. AN EMPLOYER who requests services. This may include your personal medical history, physical, laboratory and diagnostic tests (including drug screenings).

I understand that by refusing access to my medical record for care coordination, my treatment may be adversely and that I could be held liable for the full cost of services provided by Complete Health. I understand this information may contain my personal medical records (including all test results, alcohol and drug usage, mental health records, infectious disease history and treatment plans). I understand that I may revoke this consent/authorization at any time.