CONGENIAL HEALTHCARE,LLC

Family Medicine North

Consent for Services:

I request and authorize medical care as my physician, his assistant or designees (collectively called "the physicians") may deem necessary or advisable. This care may include, but is not limited to in person or via telemedicine, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my physician(s) and that other personnel render care and services to me (the patient) according to the physician(s) instructions. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to results of such diagnostic procedure or treatment.

Signature_____

Date_____

Authorization of Benefits for Insurance

Payments of any outstanding fees are requested at the time services are rendered. I agree to pay any and all charges that exceed insurance payment that are not covered by insurance. I understand that if I default on payment and my account is sent to a credit bureau or collection agency there will be services charges, equivalent to practices additional costs, added to my existing balance due. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I hereby authorize assignment and payment directly to the Practice for major medical and/or surgical benefits due to me.

Signature_____

Date_____

Notice of Health Privacy Practices

I acknowledge that I have reviewed and understand the Practice's **Notice of Health Privacy Practices**. This notice describes how the practice may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Authorization must be signed by the patient or by an authorized person in the case of a minor or when patient is physically or mentally incompetent.

Signature_____

Date_____