Consent for Treatment, Release of Information, and Assignment of Insurance Benefits

Chart Number:
Patient Name:
Date:

Consent for Treatment/Care

I consent to treatment and care by Heale Medical LLC ("HM") and its treating healthcare providers, and hereby give my voluntary informed consent and authorization for HM to perform healthcare services. I understand that my treatment and care may include routine care, such as physical examinations, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care from my health care provider. I am aware that the practice of medicine is not an exact science, and there are no guarantees about the results of my treatments, examinations, or procedures.

Consent for Use and Release of Information

I give permission to HM, including its treating providers and other staff members, to release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary: (1) for my treatment (to health care providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as necessary to obtain payment); (3) for the health care operations of HM or another health care provider that has had a relationship with me; or (4) as otherwise permitted by law.

Acknowledgement of Notice of Privacy Practices

HM's Notice of Privacy Practices is a complete description of my privacy rights as a patient of HM. By signing below, I am confirming I have received HM's Notice of Privacy Practices.

Financial Responsibility

I understand and agree that I will be charged for the professional healthcare services provided by HM and that my actual charges may be different from the charge estimates given to me. I further agree to be financially responsible for all charges billed for services received. I understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges.

Medicare/Insurance Certification, Assignment & Payment Request

I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Social Security Act. I certify that the information given by me or by my authorized representative in applying for payment for my health care under the Medicare program is correct. I request that payment of authorized benefits be made to HM on my behalf. I authorize HM to

bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to HM.

Social Security Number
I have given my social security number voluntarily. HM may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

Communications
I give permission to HM and its treating providers to contact me by telephone, utilizing voice or text messaging, at any number contained in my HM record.

Personal Property
I understand that HM does not assume responsibility for my personal belongings that I keep in my possession, and I release HM from all liability for the loss or theft of, or damage to, such belongings.

THIS CONSENT WILL BE EFFECTIVE FOR 1 YEAR AFTER THE DATE IT IS SIGNED; HOWEVER, THIS CONSENT WILL NOT EXPIRE FOR SERVICES, CLAIMS PROCESSING OR COLLECTION ACTIVITIES FOR VISITS OCCURRING WHILE THIS CONSENT WAS IN EFFECT.

I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR TREATMENT/ACTION TAKEN OR IN PROGRESS.

I AUTHORIZE HM TO RELEASE ALL RECORDS REQUIRED TO ACT ON THESE REQUESTS. I CONFIRM THAT I HAVE READ AND UNDERSTAND THIS FORM, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.

_____	_____
PATIENT SIGNATURE (or Authorized Representative)	DATE
_____	_____
PRINTED NAME	RELATIONSHIP (if not the patient)
_____	_____
WITNESS	DATE