



CONSENT FOR TREATMENT

I voluntarily give my permission to the health providers of Well Life Family Medicine and such assistants and other health care providers as they may deem necessary to provide medical services considered necessary or advisable in the course of treatment, including diagnostic x-ray examination of me, my child or ward. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from Well Life Family Medicine providers, or until I withdraw my consent in writing.

NOTICE OF PRIVACY PRACTICES

I have reviewed the "Notice of Privacy Practices" for myself / this patient.

STATEMENT OF FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of Well Life Family Medicine to me, my child or ward. I authorize the release of any medical information necessary to process my claims (if filing with insurance) and to any other provider involved in my care. I assign and authorize payments to Well Life Family Medicine for services rendered. I understand that if I suspend or terminate care and treatment, any fees for professional services rendered to me, my child or ward, will be immediately due and payable. I also understand my insurance carrier (if applicable) may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, medical necessity or categorized as experimental. **I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law.**

I certify that I have read this form and agree to its contents.

Signature of Patient or Guardian

Date

Printed Name of Patient or Guardian

Relationship to Patient

A duplicate or faxed copy of this form is considered the same as the original document.