NORTH COUNTRY medical & wellness

Patient Name: _____

DOB: _____

Consent for Treatment

I consent to evaluation and treatment of the condition for which I, or my child or dependant, have come to North Country Medical and Wellness (NCMW), and authorize the physicians and other health care providers affiliated with NCMW to provide such evaluation and treatment. I understand that health care providers in training may be involved in my care and treatment and consent to their involvement. 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, or test performed at or by NCMW. I authorize NCMW to examine, use, store and dispose of all tissue, fluids, or specimens removed from my body. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at NCMW.

Responsibility For Payment / Assignment Of Benefits / Contact

In consideration of the treatment provided at NCMW to me or my child or dependant, I agree to pay NCMW for such treatment. If private health insurance, Medicare, Medicaid, other governmental or other insurance programs cover the treatment, I authorize NCMW to bill any such insurer for all charges incurred in connection with the 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 understand and acknowledge that:

- If I elect to pay for medical treatment in cash, in full before services are provided, I can request that my health insurance, in any form, not be billed for that service or be notified that the service was provided.
- I am responsible for notification to my insurance company to obtain authorization before service is rendered, and if I do not pre-certify for such services, my benefits may be reduced or lost, but I will still be responsible for paying NCMW for the services. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan and my certificate of coverage.
- If I do not consent, or later revoke my consent, to the release of my information to any insurer that I have identified, I will be responsible to pay all list charges for the treatment and services received.

I hereby assign to NCMW and the professionals involved in my care, all my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid or any other programs that I identify for which benefits may be available to pay for the services provided to me, and authorize payment for such services to be made directly to NCMW.

If I default or do not pay for treatment provided, I acknowledge and agree that NCMW 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 or arbitration costs, and reasonable attorney's fees incurred for the purpose of securing payment. Collection expenses and/or attorney fees include the fee charged to NCMW to complete the collection. For example, if a collection agency or law firm charges 20% of the amount collected as their fee, NCMW will add 20% to my bill and the collection agency or law firm will then earn 20% of the amount collected.

Patient Rights and Responsibilities

I understand that I have the right, and the responsibility, to participate in my care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my health history and presenting complaint, to agree upon a treatment plan, and follow that plan. I understand that my health care providers will treat me with respect, and I agree to do the same for them.

I HAVE READ, UNDERSTOOD AND FULLY AGREE TO each of the above statements and sign below as my free voluntary act.

_____ _____ _____

Patient or Authorized Person Signature | Relationship & Printed Name | Date

_____ _____

Witness (printed name and signature) | Date