

AUTHORIZATION FOR TREATMENT

I authorize the Physician or Healthcare Provider or his/her designee(s) or consultant(s), in charge of the patient’s care, to administer any treatment as deemed necessary or advisable in the diagnosis and treatment of any conditions related to the patient consistent with, Advance Directive, Living Will or Durable Power of Attorney for Healthcare of file.

ASSIGNMENT OF BENEFITS, PAYMENT TERMS & RELEASE OF INFORMATION

As the Guarantor of this account, I agree to assign to the Center for Integrative Medicine all insurance benefits otherwise payable to or on behalf of the patient for services rendered. I agree to be held financially responsible for services rendered by the Center for Integrative Medicine on behalf of the patient that are not covered by insurance. I understand that it is my responsibility to notify the Center for Integrative Medicine of any changes in insurance coverage. I know that I will pay the balance owed if the insurance or personal information I have given is not true.

I authorize the release of pertinent medical records to the patient’s named insurance carrier for the purpose of claims coverage. I understand that this applies to all types of insurance coverage, including but not limited to Medical, Worker’s Compensation and Liability/Auto. I understand that the only records released would be pertinent to that date of service and to the carrier providing coverage for that date of service. Failure to provide this authorization may result in the insurance carrier’s denial of a claim. I have been given a copy of the practice’s Financial Policy when applicable and understand its contents.

I have also been given a copy of the Center for Integrative Medicine’s Notice of Privacy Practices and understand its content.

Signature: _____ Date: _____
(Patient/Legal Guardian/Guarantor)