Assignment of Benefits/Financial Responsibility/Consent to Treatment

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to An oz. of Wellness Healthcare Locations for all covered medical services and supplies provided to me during all courses of treatment and care provided by An oz. of Wellness Healthcare Locations and/or its affiliated entities or otherwise at its direction.

I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with An oz. of Wellness Healthcare Locations, which will authorize and allow for direct payment to An oz. of Wellness Healthcare Locations of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by all An oz. of Wellness Healthcare Locations.

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to An oz. of Wellness Healthcare Locations and or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify An oz. of Wellness Healthcare Locations of any changes in my health-care coverage. I understand by signing this form, I am accepting financial responsibility for all payment for medical services and/or supplies received.

Consent for treatment: Knowing that I (or the patient indicated on the top of this form) desire evaluation and/or treatment at all An oz. of Wellness Healthcare Locations, I voluntarily consent to such care. I consent to routine diagnostic procedures, including but not limited to x-rays, blood draw, laboratory tests, administration of medication and to medical or surgical treatment by physicians and staff members of all An oz. of Wellness Healthcare Locations and other health care providers who may be called upon to consult or assist in my care as judged necessary by my treating physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guaranties have been made to me as to the results of my examination or treatment at all An oz. of Wellness Healthcare Locations. I acknowledge that treatment at all An oz. of Wellness Healthcare Locations is intended to address specific episodic illnesses or injury and is not intended to substitute for comprehensive care in lieu of a primary care physician or other specialized physician. In order to provide the best chance for successful treatment I accept responsibility to follow the advice of my treating physician including compliance with medications, discharge instructions and reevaluation with follow up or referral physicians. I agree to return to the clinic or seek care in an Emergency Department of a hospital if my condition substantially changes. I further agree to hold harmless the physicians and staff of all An oz. of Wellness Healthcare Locations should I fail to comply with the above conditions.

Patients at all An oz. of Wellness Healthcare Locations will be treated regardless of race, color, age, national origin, disability or religion. Notwithstanding the above criteria, An oz. of Wellness Healthcare Locations reserves the right to refuse care to any individual who may have an unpaid balance, exhibits rude or disruptive behavior or any other reason at the discretion of the physician on duty.

This consent shall remain in force until such time as it is specifically revoked.

Signature of patient or patient representative: _____ **Date:** _____

(Representative signature required if the patient is a minor or unable to consent)

Representative's relationship to patient: _____

Patient is unable to consent because: _____

Witness: _____

Locations see website, Anozofwellness.com and navigate to contacts.