EXCELLHEALTH

PATIENT CONSENT FOR TREATMENT AND PAYMENT AGREEMENT

Treatment Consent

Treatment includes, but is not limited to: the administration and performance of all treatments received at Excellhealth, the administration of any needed anesthetics, the use of prescribed medications, the performance of procedures deemed necessary or advisable during patient treatment, the taking and utilization of cultures and medically accepted laboratory tests.

I understand my authorization is given in advance of any specific diagnosis or treatment, that these services are voluntary, and that I have a right to refuse these services. This consent will remain in force until and unless I specifically revoke consent in writing and submit it to the Privacy Officer, and I understand any revocation will have no effect on any treatment actions that were taken prior to Excellhealth receiving my revocation.

Patient Signature: ____ Date: _________________________

Payment Responsibility

Payment includes, but is not limited to: the authorization of payment directly to Excellhealth of benefits otherwise payable to me. I hereby acknowledge my medical records may be released to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for services provided, such as billing and collection services, insurance payers, automobile accident insurers, or for work related injury services.

Patients are responsible for the charges incurred for Excellhealth services. It is a courtesy of our office to file with patients' insurance; however, the patient is responsible for the co-pay and any charges for which insurance or other third party payers are not responsible for. If Excellhealth is unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place the patient's account with a collection agency, which will leave the patient liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Excellhealth all insurance or third party payments I receive for services rendered to me by Excellhealth immediately upon request.

Patient Signature: ____ Date: _________________________