WE CARE MEDICAL GROUP, PC
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CONSENTS AND ANDERSTANDING

Consent for Treatment:

I, with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body, obtaining and testing blood, tissues, fluids and other bodily samples and the prescription/ dispensing of drugs, devices, equipment or other items if required and in accordance with a treatment. This consent includes contact and discussion with other health care professionals for care and treatment. **Right to Refuse Treatment:** In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Consent and Authorization to Use and Disclosure Protected Health Information and Assignment of Benefits:

I have had a chance to review the Practice Privacy Notice as part of this registration process. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me. I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities.

Financial Responsibility Agreement:

I understand I am financially responsible for all of the charges and bills associated with my care and treatment (including annual deductibles, co-payments and other amounts that may be deemed my responsibility by the payment sources), except charges which are covered and paid by health insurance, government healthcare program such as Medicare or Medicaid, a financial assistance program, or any party responsible for payment (all of which are referred to as "Third Party Payers"). I authorize We Care Medical Group, PC to submit bills or claims and related information concerning my health status, care, treatment, and payments made for my care and treatment to any applicable Third Party Payer and its business associates. I also authorize such Third Party Payers to make payments directly to We Care Medical Group in response to these bills or claims. I understand that if I have an insurance co-payment, I am expected to make payment when checking in for my appointment. I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same and can vary by employer group. We Care Medical Group is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

Missed Appointments and Cancellations:

Our policy is to charge for missed appointments without prior notification at a rate of $15. This fee is not covered by your insurance plan and is your responsibility. Our policy, at the discretion of the provider, is to terminate a patient from the practice after 3 missed/canceled (without 24 hours' notice) appointments.

THANK YOU FOR YOUR UNDERSTANDING AND COOPERATION WITH OUR POLICY.
ANY QUESTIONS I HAD ABOUT THIS CONSENT FORM HAVE BEEN ANSWERED. I UNDERSTAND THE INFORMATION IN THIS FORM AND AGREE TO THE CONDITIONS SETFORTH ABOVE. THIS CONSENT SHALL REMAIN EFFECTIVE UNTIL I REVOKE IT INWRITING, WHICH I MAY DO AT ANY TIME.

X_____

Patient or Authorized Representative (Name and Signature) **Date**

Relationship of Authorized Representative: _____

(Parent, Guardian or Healthcare Agent)