

Authorization and Release for ALL Patients: I permit copies of this authorization to be used in place of the original.

I understand that:

- As the patient, I am responsible for the bill, regardless of any insurance coverage and that all balances are due upon receipt of the bill.
- If I have an office visit my co-pay is due at the time of service, If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will plan to pay or be billed for any outstanding balances in accordance with
- I understand that my insurance may not cover all charges deemed medically necessary by Alonso Medical
- I also understand that I am responsible for any part of the charges that are not covered by my insurance, and I will be billed directly for those services.
- I will be charged \$25 for any return check fee if my bank returns my check to Alonso Medical and Wellness
- I will be charged \$75 for a no-show appointment that was not canceled within 24 hours. This must be paid prior to your next visit. If I repeatedly fail to show up for or cancel appointments, I may be asked to find another physician.
- For any copies of labs/notes that I am requesting I will pay \$1.00 per page for the first 25 pages and . 25 cents after.
- Prescription refills require an office visit, the pharmacy must call not fax prescriptions with any issues with a prescription.

I Authorize:

- Use of this form on all my insurance claims and release of information to my insurance companies.
- The doctor acts as my agent in helping to obtain payment from the insurance companies
- Release of protected health information regarding services rendered by physicians and employees of Alonso Medical and Wellness Center.

#### Consent for treatment

I, \_\_\_\_\_ (please print name) am voluntarily seeking medical care and treatment from Alonso Medical and Wellness, I give permission to the medical to examine me, make diagnoses, and provide treatment to me in accordance with the information, explanations and recommendations they provide me.

Patient signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_