CONSENT FOR CARE AND TREATMENT

I, _____, give my consent to Carlson Therapy Network, P.C. (DBA Carlson Procare) to furnish medical care and treatment that is considered necessary and proper in diagnosing or treating my physical and medical condition.

AUTHORIZATION OF BENEFIT ASSIGNMENT,
FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION

I authorize Carlson Therapy Network, P.C. to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to Carlson Therapy Network, P.C. from my insurance carrier or third party payer.

I agree to pay any applicable copayments and balances at the time of service as agreed between Carlson Therapy Network, P.C. and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand that if I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, legal fees and the 28% collection agency fees above and beyond the owed balance.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have read and understand the Carlson Therapy Network, P.C. Notice of Privacy Practices. I understand that by signing this consent, I am giving my permission to Carlson Therapy Network P.C. to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and Carlson Therapy Network, P.C. will always post the current notice at the clinic, on the website and have copies available for distribution.

Indicated below are person (s) whom Carlson Therapy Network, P.C. may speak with regarding my treatment:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

Listed below are individual (s) whom I request RESTRICTION regarding my protected health information.

_____ _____

SIGNATURE FOR CONSENT

By my signature below, I acknowledge that I have read, understood and agreed to the terms and conditions contained in the ***Consent for Care and Treatment***, the ***Authorization*** to release all information necessary to secure payment and the ***Consent For Use and Disclosure of Health Information***.

_____ _____

Signature of Patient/Guardian/Responsible Party **Date**