Privacy and Billing Procedures
Authorization and Acknowledgment

These authorizations/acknowledgements cover all services rendered to me, or the patient I am signing for, today and all future dates of service. I understand I may revoke this authorization by informing Elina Healthcare, Inc. in writing, but if I do revoke this authorization, it will not affect anything prior to the date the revocation is received by Elina Healthcare, Inc.

Acknowledgements of Receipt of Notice of Privacy Practices
Authorization to Release Information to Family, Friends, or Others

I have received a copy of Elina Healthcare, Inc.'s Notice of Privacy Practices. I authorize Elina Healthcare, Inc. to release any information regarding my treatment; including lab results, x-rays and medical records, to the following individuals/entities:

Name:_____Phone Number:_____Relationship to Patient:_____

Name:_____Phone Number:_____Relationship to Patient:_____

Name:_____Phone Number:_____Relationship to Patient:_____

Elina Healthcare, Inc. will use my phone number and address provided during the registration to contact me regarding my treatment; including lab results, x-rays, and medical records. I will ensure this information is current and up-to-date at every visit.

Authorization to Treat and Bill

I consent to be treated by Elina Healthcare, Inc. If I am not the patient being treated, I am authorized to consent to treatment and billing for the patient identified below. I authorize Elina Healthcare, Inc. to bill my medical insurance for the care that I receive and to release any information the insurance carrier requires to process this bill. I authorize payment of medical benefits to Elina Healthcare, Inc., or to outside labs as a described below, for all services performed and billed by Elina Healthcare Inc. I understand that I am responsible for the charges for the treatment I received at Elina Healthcare, Inc. I understand that Elina Healthcare, Inc. providers utilize the Prescription Drug Monitoring Program. To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service, Elina Healthcare, Inc. may deny services.

As a courtesy, Elina Healthcare, Inc. will bill my medical insurance. If I do not provide complete, current, and accurate insurance information to Elina Healthcare, Inc., I understand that Elina Healthcare, Inc. may not receive payment from my insurance carrier and I will be entirely responsible for my bill. Even after my medical insurance company pays Elina Healthcare, Inc. I may owe Elina Healthcare Inc. payment for services not covered by my insurance and I agree to pay these promptly. I understand Elina Healthcare, Inc. may send lab specimens to an outside laboratory. I authorize any lab performing services for me to bill my medical insurance for their services. I understand that medical insurance may not pay for all services provided by the lab and I agree to pay any remaining balance promptly to any outside lab providing services to me. I understand that Elina Healthcare Inc. is not responsible for payment to outside labs for tests provided to me.

I understand that if I fail to pay Elina Healthcare, Inc. for services provided to me, **the balance owed <u>may be sent to collections</u>.** I understand that once my account is sent to collections, **I WILL NOT be able to be seen at any Elina Healthcare, Inc. locations** until the balance is paid in full. I understand that I may contact Elina Healthcare, Inc. to establish payment arrangements to avoid additional charges.

Patient Name:_____Date:_____

Patient/Guardian Signature:_____Date of Birth:_____

Name of Guardian:_____Relationship:_____