4766 Rowan Rd, New Port Richey, FL 34653

Email: naturalclinicmd@gmail.com Phone: 727-753-8861 Fax: 888-849-6158

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/treatment by Natural Clinic MD, deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature: _____Date:_____

FINANCIAL RESPONSIBILITY & AUTHORIZATION

I understand and agree, that I am ultimately responsible for the copayments and balances of any charges incurred. I also understand that I am ultimately responsible for any charges incurred if my account is sent to a collection agency. I understand that insurance does not cover for any of the treatments or related expenses. I agree to take full responsibility for any unpaid balance and that such payment will be made to this physician's office for services.

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or any change in the above information.

Signature:_____Date:_____

Designated Relative

I authorize discussion of my general medical and diagnosis (including treatment, payment, and healthcare operations) with:

___Spouse ___Children ___ Other _____

Please list the family members or significant others, if any, whom we may inform about your medical condition, in case of emergency:

Name :_____Ph:_____

Name:_____Ph_____

Signature :_____Date_____

If you would like to view the Natural Clinic MD HIPAA Policy, please notify the front desk