Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information

I hereby certify that the insurance information I have provided is accurate, complete, and current and no other coverage or insurance exists. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize LJ Medical to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay LJ Medical directly, I agree to forward to LJ Medical all health insurance payments which I receive for the services rendered by LJ Medical and its health care providers. I authorize LJ Medical or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my insurance plan does not participate in the LJ Medical network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification

In consideration of the services provided by LJ Medical and its providers, I agree that I am responsible for all charges for services provided that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges which are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse LJ Medical for all costs, expenses and attorney's fees incurred by LJ Medical to collect those charges.

I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plan's provisions. I understand that my failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

Consent to Treatment

As a LJ Medical patient, I voluntarily consent to the rendering of such care and treatment as the LJ Medical providers and personnel, in their professional judgment, deem necessary for my health and well-being. If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and understand I may terminate such visit at any time.

My consent shall include medical examination and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), and vaccine administration. My consent shall also include the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my LJ Medical provider nor any care center staff has made any guarantee or promise as to the results that may be obtained.

Consent to call

I understand and agree that LJ Medical may contact me using automated calls, emails, and text messaging sent to my landline and mobile device. These communications may notify me of appointments, preventative care, test results, treatment recommendations, outstanding balances, or any other communications from LJ Medical.

I understand that I may voluntarily "opt-in" to receive automated text message communications from LJ Medical by informing my provider's staff or visiting "My Profile" on my LJ Medical Patient Portal, and agreeing to any additional Terms and Conditions established by my mobile carrier.

I hereby acknowledge that I have received LJ Medicals' Financial Policy and LJ Medicals' Notice of Privacy Practices. I agree to the terms of LJ Medicals' Financial Policy, LJ Medicals' Notice of Privacy Practice and consent to my treatment by LJ Medical providers. This form and assignment of benefits applies and extends to subsequent visits and appointments with LJ Medical providers.

Printed Name of Patient: _____ **Email:** _____

Signature: _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.