**Patient Care Agreement**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the medical care and treatment tendered to the patient as deemed necessary or advisable in the judgment of the MAXHealth (“MAXHealth”) physician or other health care provider. I understand that, prior to rendering treatment, the physician or other health care provider will explain my medical care and treatment, including an explanation of treatment alternatives and the risks associated with such treatment. I acknowledge and consent to the following:

1. AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD-PARTY PAYMENTS: I hereby expressly authorize MAXHealth and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to MAXHealth and all professionals providing for such care, and I hereby assign such sums to them. I understand this authorization and assignments shall remain valid unless I provide written notice of revocation to MAXHealth and the third-party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.
2. NOTICES OF PRIVACY PRACTICES: I acknowledge I have received a copy of MAXHealth’s Notice of Privacy Practices on or before the date signed below. A copy of MAXHealth’s Notice of Privacy Practices is also located here: mymaxdoc.com.
3. PAYMENT FOR SERVICES: I agree to pay MAXHealth for services rendered. If I am insured by a health insurance plan in which Best Value participates, Best Value will submit a claim to my insurance carrier. I understand that my insurance coverage is a contract between me and my insurance company, and not MAXHealth. I understand that I am responsible for any charges denied by my insurance carrier along with any charges classified by my insurance carrier as a deductible, co-payment, and/or coinsurance.

**By signing this document, I certify that I have read, understand and agree to its contents and that information provided by me is accurate and complete. A copy of this document may be utilized the same as the original.**

**Patient/ Representative** [Print]: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient/ Representative**  [Signature]: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE [mm/dd/yyyy]**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not signed by patient, please provide documentation of legal representative status:

Attached: [ ] Do not have copy: [ ]