Authorization for Treatment/ Financial Agreement

CONSENT FOR TREATMENT: I consent to medical, surgical, or diagnostic services discussed and ordered by a physician and given by Rainier Medical and its associates. Rainier Medical and its associates may share health information about me, my guardian(s) or parent(s) to physicians and providers who treat me.

RELEASE OF INFORMATION: I permit Rainier Medical and its associates to release information needed for eligibility and benefits, and to process claims for payments. I agree that all insurance payments be paid directly to Rainier Medical for services given.

FINANCIAL AGREEMENT: I agree to pay Rainier Medical for services at regular rates and terms. I permit Rainier Medical and its associates to appeal any denial received from my insurance company. If a third party payer will not pay, I agree to pay for the services given. If my bill is sent to a lawyer or collection agency, I agree to pay all reasonable attorney's fees or collection costs. I further understand that:

______ Even if we are contracted with your insurance, the cost of your professional services may not covered. Each claim is evaluated separately. Coverage is determined based on the terms of your personal health insurance policy and the insurance company's determination of medical necessity. Coverage for certain codes or diagnoses differ. While we do our best to use codes that are covered whenever medically appropriate, it is ultimately your responsibility to know your benefits including how many preventive counseling sessions you are allowed. If your insurance claims are denied, or required to be refunded, I will pay for services out of pocket.

______I understand there is a "No Show" and "Late Cancellation" fee applied for appointments cancelled with less than 24 business hours notice. Currently, the fee is $50 but is subject to change without notice. Past due amounts are subject to an interest rate, currently 7% APR, but subject to change without notice.

______ Certain costs may not covered by insurance, such as body composition analysis (if applicable), enrollment fee (if applicable) program materials fee (if applicable), and some specialized testing and medical foods, for example.

PHOTOGRAPHS: For diagnosis and treatment, photographs may be taken and used. This includes video or otits electronic monitoring or recording methods. These pictures may be used to add information about my illness or injury. Photographs may also be taken for identification purposes. A separate consent is needed to use any photographs for marketing purposes. I understand I must obtain the permission of my health care provider(s) for personal videotaping or audiotaping.

FOLLOW-UP CALLS: I agree that Rainier Medical and business associates may to call me at whatever phone numbers I have provided, to include your home phone, work phone, and mobile phone, regarding outstanding balances and any other matters related to your treatment at our facility or to make a follow-up call to me at my home to ask how I am feeling or help with follow-up care. They may leave a message with any member of my household if I am not there or if I am unable to take the call.

Signature: ____ Date: ______________________