CONSENT TO TREAT AND BILL

As a patient being treated at Coia Comprehensive Primary Care, LLC, I agree to the following terms:

- I acknowledge that it is my obligation to make Coia Comprehensive Primary Care, LLC aware of any changes in my health insurance information. Should I fail to provide the necessary information to have my insurance claim properly adjudicated, I agree to assume full financial responsibility for services rendered to me by the provider. Further, should I neglect to make payment within 30 days of receiving a statement I understand that I may be responsible for interest, attorney fees and court costs. I also understand that delinquencies in payment are reported to a national credit reporting agency.

- I hereby acknowledge that I have presented myself for medical treatment. I authorize the providers(s) who are about to treat me to order and/or administer any treatment and or perform such procedures as may be deemed necessary or advisable in the diagnosis and treatment of my illness or injury. I further understand that these procedures, lab tests, x-rays, etc. may be at additional cost and by consenting to them I accept financial responsibility for payment of such. I acknowledge that all payments and co-payments are due at the time of service.

Assignment of Insurance Benefits:

I hereby authorize direct payment of medical benefits to Coia Comprehensive Primary Care, LLC for services rendered in person or under their supervision. I understand that I am financially responsible for any balance not covered by my health insurance.

I hereby authorize Coia Comprehensive Primary Care, LLC to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

A photocopy of these assignments shall be as valid as the original.

Patient Name (please print): _____ DOB: _____

Signature of patient or responsible party: _____ Date: _____

If signed by Representative, relationship: _____