PATIENT INFORMATION (please print)

Name: _____

Date of Birth: _____

Address: _____

_____

PATIENT ACKNOWLEDGEMENT FORM

▪ CONSENT TO MEDICAL TREATMENT

As a patient of Voyage Healthcare, I consent to the medical care and treatment, as deemed necessary, advised and agreed upon with my physician or other Voyage Healthcare provider(s). Medical care and treatment may include but are not limited to laboratory procedures, x-ray examination, medications or other services rendered to me during general appointments at Voyage Healthcare. I understand that a specific consent process may be required under certain circumstances

▪ FINANCIAL POLICIES

CLINIC PAYMENT POLICY: Voyage Healthcare issues monthly statements to patients and requires payment of account balances in full each month.

AGREEMENT: The insurance information I provided to the clinic is true and correct and is hereby given to the clinic for the purpose of receiving medical care. As responsible party of the account, I understand this policy and agree to pay for such treatment under the terms of the clinic as outlined.

ASSIGNMENT OF BENEFITS: I hereby authorize and direct my insurance carrier(s) to issue payment directly to VOYAGE HEALTHCARE, PA for any services provided to me for which I am entitled to receive medical benefits. A copy of this can be considered as an original for insurance purposes. I understand that I am responsible for any amount not covered by my insurance.

▪ NOTICE OF PRIVACY PRACTICES

I have been informed of and/or offered a copy of Voyage Healthcare's Notice of Privacy Practices.

ACKNOWLEDGEMENT

I have read, understand and agree with the above stated information, authorizations and agreements. I understand this authorization will be in effect for **12 months**, unless cancelled by me in writing and that my cancellation will take effect when VOYAGE HEALTHCARE receives my written notice.

PATIENT SIGNATURE* _____

*Patients 18 years of age and older must sign for themselves

If other than patient, please state relationship _____

DATE _____ / _____ / _____