Consent to Treatment

I am presenting myself for examination and treatment at Nonnie M Estella MD, PC and I voluntarily consent to the rendering of such care encompassing routine diagnostic procedures and medical treatment by the medical staff and its employees as in their professional judgement be deemed necessary or beneficial. I further authorize electronic access of my pharmaceutical records, if applicable, for treatment purposes. I understand that my records will only be accessed by authorized individuals.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations in the practice.

I understand that information about my health may be disclosed to public health authorities charged with preventing or controlling disease.

Date:____________________ Signature of Patient or Parent if Minor*:____

*By signing above, I acknowledge that Nonnie M Estella MD, PC has informed of their **Notice of Privacy Practices (NPP)** for the protection and security of my healthcare information. I also acknowledge that upon request, Nonnie M Estella MD, PC will provide me with a copy of the **NPP**.

Financial Consents

Authorization to Release Information: Nonnie M Estella MD, PC is authorized to release to any insurance companies having coverage on me (or to the employer if coverage is under a group insurance plan any information pertaining to the diagnosis and/or procedures relative to this practice visits. A photocopy or digital copy of this authorization shall be considered as effective and valid as the original.

Assignment of Insurance Benefits and Rights of Recovery: In consideration of services rendered, I hereby forever assign and give to Nonnie M Estella MD, PC all rights, title and interest in the benefits payable for services rendered by said practice, provided by my policies of insurance. This transaction shall be for the recoveries on said policies but shall not be construed to be an obligation of Nonnie M Estella MD, PC to pursue any such right of recovery. Provided however, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier. I hereby authorize the insurance companies to pay directly to Nonnie M Estella MD, PC all benefits due under said policies by reason of services rendered therein. I shall pay Nonnie M Estella MD, PC for all charges in excess of the sums actually paid pursuant to said policies. A photocopy or digital copy of this authorization shall be considered as effective and valid as the original.

Date: ____________________ Signature of Patient or Parent if Minor: ____

Medicare Certification

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct, I authorize Nonnie M Estella MD, PC to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize the payment of these benefits directly to Nonnie M Estella MD, PC on my behalf for any services and materials furnished. I authorize any holder of medical information about me to releasee to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. I further agree that I will furnish evidence along with the medical insurance policy numbers that said insurance plan payments have been exhausted or unavailable for payment prior to payment submission and anticipation of payment by Medicare. I assign payment for the unpaid charges for certain physician's services, I understand that I am responsible for any health insurance deductibles and coinsurance.

Date: ____________________ Signature of Patient or Parent if Minor: ____

Authorization to Release Information

I allow Nonnie M Estella MD, PC to speak to ______________________________ (Name), ____________________ (Relationship), regarding my care.

I allow Nonnie M Estella MD, PC to leave a message on my home or mobile number, to text or email regarding any appointments or test results.

Date: ____________________ Signature of Patient or Parent if Minor: ____

Consent to Health Information Exchange

I consent to allow my provider to use Health Information Exchanges (secure computer networks that allow participating health care and insurance providers nationwide to access healthcare information to enhance coordinate of care) to disclose information to the healthcare organizations or providers. I understand that I have a right to request and receive an accounting of disclosures of access to my information through the HIE at any time.

Date: ____________________ Signature of Patient or Parent if Minor: ____

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