Mailing Address: 530 E Hunt HWY

Suite 103 #485

San Tan Valley AZ, 85143

480.442.5863

FEE FOR SERVICE

MEDICAL AGREEMENT

Print Patient Name______________________________ Date of Birth__________

Street Address____

City, State, Zip____

Cell Phone_______________________Email_________________________________

I Agree to Text and email Communication:

- ☐ Yes
- ☐ No

Patient or Guardian: ________________________ Relationship to Patient: ___________

1. Medical Consent: I consent to any medical treatments or procedures which may be performed on an outpatient basis (excluding emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of **Healing Hands Medical Clinic** assisting my care.

2. Financial Obligation: I understand that all Fee For Service (FFS) charges are due at the time of service. I agree to pay **Healing Hands Medical Clinic** for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. The Fee For Service charges are as follows:

Acute care $95 per visit,

3. Acceptable forms of payment include Cash, Visa, MasterCard, Discover, Debit card and HSA,

. If I am a non-insured patient, I agree to pay for my visit in full at the time of service.

4. **Non-Participation in Insurance.** The Practice does not participate with any health plans, HMO panels, or any other third-party payor. As such, we will not submit bills or seek reimbursement from any third-party payors for the Services provided under this Agreement.

5. **Medicare.** The Patient understands that the Practice and staff have opted out of Medicare. As a result, both the Patient and the Practice shall be prohibited by law from seeking reimbursement from Medicare for any Services provided under this Agreement.

6. Release of Medical Information: I hereby authorize **Healing Hands Medical Clinic** to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in the care of the above-named patient.

7. The undersigned certifies that he/she has read and agree to the above and foregoing, and received a copy thereof, and is the duly authorized to enter this FFS agreement.

Patient or Guardian Signatures: ________________________________Date: ___________