OPTIMUM HEALTH

6354 Walker Lane Suite 350
Alexandria, VA 22310

Authorization and Consent to Treatment

Authorization for medical treatment: I hereby authorize to the care and treatment that my healthcare provider and employees of Optimum Health LLC, in their professional judgment, deemed necessary for my health and well-being. Should I request or initiate a telehealth visit, I also consent to participate in such a visit and it's recording with the understanding that I may terminate the visit at any time. This consent applies to medical examinations, diagnostic testing, minor surgical procedures, administration/injection of pharmaceutical products and medication and drawing of blood. This consent shall also cover the carrying out of the orders of my treatment provider by Optimum Health LLC staff. I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment or extermination at Optimum Health LLC.

Assignment of benefits, guarantee of payment and pre-certification: I hear by assign to Optimum Health LLC any and all rights, title, and interest that I have in any insurance proceeds or benefits payable to me or on my behalf for services rendered to me by Optimum Health LLC, whether such services are considered in-or out-of-network with respect to any third-party payers. I therefore hereby authorize and direct any payment of authorized benefits under Medicare, Medicaid, and or/any of my insurance carriers to make payment of any and all such amounts directly to Optimum Health LLC rather than to myself or any other insured. I acknowledge that as a member of a healthcare plan, I may be responsible for notifying my primary care physician or obtain pre-certification for services. I understand that I'm financially responsible to optimum health LLC for all charges, including those not paid by insurance or healthcare plans for services, not authorized as specified in my benefit package, incurred by me or in my behalf.

Release of medical information: I hear by authorize and direct optimum health LLC to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, healthcare plans and third-party payers.

Consent to call, email, and text: I hear by consent to Optimum Health LLC or a business associate of Optimum Health to contact me by automated calls, emails and/or text messages sent to my landline and/or mobile devices, email, or home address

reflected on my account. I understand that by giving this consent Optimum Health LLC may contact me about my medical care, treatment recommendations, outstanding balances and any other communications from my provider. I understand that I may opt-out of receiving all such communication from my provider by notifying my provider staff or by visiting updating my patient portal.

HIPAA: I understand that my Providers Privacy notice is available on my provider website and that I may request a paper copy at my provider reception desk.

I hereby acknowledge that I have received my provider's Financial Policy, as well as my provider's Notice of Privacy Practices. I agreed to the terms of my provider's Financial Policy, the sharing of my information via HIE and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Optimum Health LLC providers.

To be signed by patient or legal authorized representative

Patient Name: _____Date of Birth: _____

Signature: _____Date: _____

Name and Relationship of person signing, if not the patient:

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