AstranaCare

Patient Name: _____ **Date of Birth**_____

Consent to Treat I (or the undersigned on behalf of the patient) voluntarily consent to allow Astrana Care Physicians and/or staff to provide health care, encompassing routine diagnostic procedures and treatments, as an outpatient on continuing basis as deemed necessary by the Astrana Care Physicians. I am to be informed about the length and course of all treatment and am free to terminate treatment with Astrana Care at any time.

Release of Information I hereby authorize Astrana Care to release any necessary medical information to my insurance carrier or its agents in order to secure payments. Separate and specific authorization is needed for the release of HIV test results, psychiatric and chemical/alcohol treatment.

Assignment of Insurance Benefits I hereby assign medical and/or surgical benefits, insurance, and other health plan benefits to Astrana Care. A copy of this assignment is considered valid in lieu of the original.

Financial Agreement I understand that I am financially responsible for all charges and copayments not paid by my insurance company, except the amounts exempted by my insurance company's contract with Astrana Care. Should the account be referred to any attorney for collection or to a collection agency, the undersigned shall pay for all legal fees and collection expenses incurred. All delinquent accounts shall bear interest at the maximum rate by the State of California.

Certification I certify that I read or have been read the foregoing and have received a copy for my records. As the patient, the patient's guardian, conservator, or general agents, I agree to abide by the above terms.

If signed by someone other than patient, indicate relationship below.

_____

_____ _____

Client Signature Date

_____ _____

Witness Signature Date