AstranaCare

Consent to Treat

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

I hereby give my consent for treatment (or, the undersigned on behalf of the patient, voluntarily give consent) to allow the physicians and/or staff of Astrana Care to provide medical care, which includes routine diagnostic procedures and treatments, as an outpatient on an ongoing basis as deemed necessary by the physicians at Astrana Care. I will be informed of the length and course of any treatment, and I am free to end treatment at any time.

I hereby authorize Astrana Care to release any necessary medical information to my insurance company or its agents for the purpose of securing payment. A separate, specific authorization is required for the release of HIV test results, psychiatric treatment, or substance/alcohol abuse treatment.

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

I understand that I am financially responsible for all charges and co-payments not paid by my insurance company, except for amounts waived by Astrana Care's agreement with my insurer. If my account is referred to an attorney or collection agency for collection, the undersigned agrees to pay all legal fees and collection costs incurred. All delinquent accounts will accrue interest at the maximum rate allowed by the State of California.

Certification: I certify that I have read or had the above read to me, and that I have received a copy for my records. As the patient, guardian, conservator, or general agent, I agree to abide by the above terms.

If signed by someone other than the patient, indicate your relationship: _____

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____