Authorization and Release for ALL Patients: I permit copies of this authorization to be used in place of the original.

I understand that:

- As the patient, I am responsible for the bill, regardless of any insurance coverage and that all balances are due upon receipt of the bill.
- If I have an office visit my co-pay is due at the time of service, If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will plan to pay or be billed for any outstanding balances in accordance with
- I understand that my insurance may not cover all charges deemed medically necessary by Alonso Medical
- I also understand that I am responsible for any part of the charges that are not covered by my insurance and I will be billed directly for those services.
- I will be charged $25 for any return check fee if my bank returns my check to Alonso Medical and Wellness
- I will be charged $50 for a no-show appointment that was not cancelled within 24 hours. I will be charged $75 after I have no showed 3 times. This must be paid prior to your next visit. If I repeatedly fail to show for or cancel appointments, I may be asked to find another physician.
- Any copies of labs/notes that I am requesting I will pay $1.00 per page for the first 25 pages and . 25 cents after.
- Prescription refill require an office visit, pharmacy must call not fax prescriptions with any issues with a prescription.

I Authorize:

- Use of this form on all my insurance claims and release of information to my insurance companies.
- The doctor acts as my agent in helping to obtain payment from the insurance companies
- Release of protected health information regarding services rendered by physicians and employees of Alonso Medical and Wellness Center.

Consent for treatment

I, _____ (please print name) am voluntarily seeking medical care and treatment from Alonso Medical and Wellness, I give permission to the medical to examine me, make diagnoses, and provide treatment to me in accordance with the information, explanations and recommendations they provide me.

Patient signature: _____ Date: ____/____/____