TRI-ESSENCE CARE, PLLC
1121 S.E. Dock Street
Oak Harbor, WA 98277-4067

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General Consent to Treatment

I, the undersigned patient or patient's representative, request care and treatment from Tri-Essence Care, PLLC (the "Clinic"). I certify that the information I am giving is correct. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees or promises have been made as to the result of treatment or examination. I consent to and authorize, for the duration of my treatment, the following:

Medical/Behavioral Consent: I consent to all medical treatment, laboratory, diagnostic imaging, and other medical procedures performed or prescribed by the healthcare provider during my visits to the Clinic.

Release of Medical/Behavioral Information: I authorize the Clinic to release any information (including information in my medical record) necessary to facilitate processing of insurance claims and/or audit of payments relative to Clinic visits to any health care insurance company, Medicare, Medicaid and other third party payor or its designee. I also consent to the release of any information, as needed, to my referring and primary physician, and to other healthcare practitioners, facilities or agencies as I direct or as required by law.

This authorization may be revoked in writing at any time, except to the extent that actions have been taken in reliance on it. I will be financially responsible for charges incurred for treatment if revocation or refusal to authorize the disclosure of healthcare information results in denial of payment.

Financial Agreement: I hereby acknowledge that I have individual financial responsibility for services rendered that are not covered by insurance or any other party liable to me. The Clinic reserves the right to impose reasonable financing and late charges, as well as reasonable costs, attorneys' fees and expenses incurred in the collection of my account should it become delinquent. Financial responsibility will be reduced or waived if charity care eligibility is determined. I am entitled to a copy of this financial agreement at the time I sign it.

Assignment of Insurance Benefits: In the event I am entitled to medical benefits of any type whatsoever arising out of any insurance policy insuring me or any other party liable to me, said benefits are hereby assigned to the Clinic for application to my bill, and it is agreed that the Clinic may apply any such payment, and such payment shall discharge the insurance company of any and all obligations under the policy to the extent of such payment. I am responsible for charges not covered by this assignment. I authorize all insurance payments to be made directly to the Clinic, including any insurance or third party payor coverage. If I am eligible for Medicare, I authorize the Clinic to bill and collect from Medicare directly.

Medicare Certification: I certify that the information given by me or on my behalf in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (This consent applies only when applicable.)

Personal Valuables: I acknowledge that the Clinic is not be liable for the loss or damage of any of my personal property, including any money, jewelry, documents or other articles of value.

Certification by Responsible Party: I certify that I have read and understand the foregoing and have received a copy of this Consent. I am the patient or am duly authorized by the patient as the patient's legal agent or representative to execute this Consent and accept its terms. If signing as the patient's legal agent or representative, all references in this Consent to "me," "my" or "I" shall be deemed to refer to the patient, where applicable.

____ ______________________________
Patient or other legally responsible person's signature Date

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Relationship of legally responsible person to patient