



Authorization to Treat

Your privacy is important to us. Upon request, a printed copy of the Solantic [HIPAA Notice of Privacy Practices](#) is available for your review. If you have requested and received a copy, your signature below indicates the date of receipt. If you have already received a copy and are declining a duplicate copy, your signature below indicates date of refusal.

Signature: _____ Date: _____

I, _____ hereby authorize the staff of Solantic, LLC to provide me with medical treatment. I agree to inform Solantic, LLC if I have any concerns about my medical treatment at the time services are being rendered.

We / I _____, the parent(s) / guardian(s) of _____ give Solantic, LLC and its employees the right to treat my son / daughter or legal ward.

Release of Information Please Initial

The medical records concerning patient care are the property of Solantic, LLC and are maintained for the benefit of the patient, the medical staff and the center. I hereby authorize Solantic, LLC to release information and or copies of my medical records to physicians, any guarantor of payment on my account, insurance companies (and other third party payors, including workers' compensation carriers and the patient's employer) for which I have assigned benefits for my treatment or care. This includes authorization to release information pertaining to: psychiatric and/or psychological care, alcohol and/or substance abuse, serologic test results (including but not limited to Acquired Immune Deficiency Syndrome or positive HIV results.) I authorize the provider to use all available means of communication to transmit such information, including electronic mail or electronic fax transmissions.

Initials box with an upward arrow.

Medicare Please Initial

All patients must check one box in the Medicare section. All patients that have Medicare Part B coverage must complete the MSP Questionnaire.

- I confirm that **I am not enrolled** in Medicare Part B.
- I have Medicare Part B for primary insurance.
- I have Medicare Part B as my secondary insurance.

Please provide your Medicare card along with your primary insurance card if applicable.

Initials box with an upward arrow.

Credit/Debit Card Authorization Consent

I hereby authorize Solantic to securely maintain my credit/debit card information on file to cover my financial responsibility for treatment rendered. Solantic will credit/debit the designated account for the full amount of charges due upon receipt of my insurance company's Explanation of Benefit (EOB). I agree to assign my insurance benefits to Solantic and agree that this authorization is valid for one year.

Initials box with an upward arrow.

Cardholder Signature: _____ Date: _____

Assignment of Benefits Please Initial

The undersigned, whether signing as a patient, representative or guarantor, hereby authorizes direct payment of any insurance benefits otherwise payable to or on behalf of the patient to Solantic, LLC. I hereby assign to Solantic, LLC all medical benefits otherwise payable to me by virtue of my visit to Solantic, LLC. I hereby direct the insurer to pay such benefits directly to Solantic, LLC in consideration of the professional services rendered to me or my insured dependent or any insured person designated in my policy. I understand I will be responsible for payment of services not covered and/or denied by health insurance.

Initials box with an upward arrow.

Radiology Please Initial

I understand that if my treatment requires radiology procedures (X-ray), it is my responsibility to inform the medical staff if I am pregnant or think I may be pregnant.

Initials box with an upward arrow.

I understand that if symptoms persist I should seek additional medical care.

Signature: _____ Date: _____

IF YOU HAVE BEEN A PATIENT AT SOLANTIC BEFORE TODAY, PLEASE COMPLETE THE FOLLOWING SECTION

Patient: _____
Last Name First Name Middle Initial Age Date of Birth SSN #

Contact Information: _____
Home Phone Cell Phone Please verify Email Address

Information Changes: _____
Please list ANY CHANGES in insurance, address or phone number since your last visit

Reason for Today's Visit: _____

Is this visit due to a work-related injury? Yes No _____
Name of Employer

Payment Method: Cash Check Credit Card _____
Insurance