Mind, Body, Spirit Wellness Center
13121 Atlantic Blvd. Ste 4
Jacksonville, FL 32225

AUTHORIZATION FOR TREATMENT

I hereby authorize the giving of all treatments, test performance of all operations, the administration of all anesthetics, and any and all other technical procedures, including consultations with other physicians, which in the judgment of my physician, may be considered necessary of advisable for the diagnosis or treatment of the patient named herein, while a patient in the care of Mind, Body, Spirit Wellness Center.

PAYMENT AGREEMENT

I promise to pay to the order of Mind, Body, Spirit Wellness Center on demand the outstanding balance remaining from time to time for the services rendered to the patient. Demand shall be considered as accomplished by the presentment of a billing. A statement of charges for medical services preformed will be forwarded by Mind, Body, Spirit Wellness Center. Any monies payable by insurance companies, assigned to and received by Mind, Body Spirit Wellness Center will be credited to the balance due. The assignment of insurance companies does not alter the undersigns obligation to pay. Mind, Body, spirit Wellness Center reserves the right to decline further services to the patient with due notice, to accept periodic installment payments waving its rights to demand payment in full as outlined above, and the right to assign the monies due under this agreement. This agreement shall be binding according to the laws of the State of Florida. Should this account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of the collection including court costs, sheriff's fees, prejudgment interest, and a reasonable attorney fee.

AUTHORIZATION AND ASSIGNMENT MEDICARE BENEFICIARY ONLY

Patient's certification, authorization to release information, and payment request. I certify that the information given to me 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 payment of authorized Medicare benefits on my behalf for any services rendered by Mind, Body, Spirit Wellness Center. I understand that any overpayment created by insurance or individual personal payments may be applied to any other personal accounts I may have with Mind, Body, Spirit Wellness Center.

AUTHORIZATION AND ASSIGNMENT/INSURANCE ASSIGNMENT

I hereby assign Mind, Body, Spirit Wellness Center insurance benefits on all insurance polices otherwise payable to me. I authorize Mind, Body, Spirit Wellness Center to submit insurance claims to insurance companies and apply insurance proceeds to my bill and to make refunds to insurance companies as refunds are due, under the provision of the insurance policies. I authorize my insurance carrier or plan administrator all insurance claims, forms, questionnaires and all other statements or documents required by my insurance carrier. I further authorize Mind, Body, Spirit Wellness Center or its billing agents or suppliers, to release information necessary to apply for payment for these benefits. I direct my insurance carrier to accept a photocopy of this assignment in lieu of the original.

Print Patient Name	Date	Signature of Patient
Witness	Date	Signature of Witness