MURFREESBORO BIO RENEW & IV INFUSION CLINIC

Authorization to Release Information to Insurance Companies

I hereby authorize BioRenew health care providers or their agents, by signing this form, to release such patient-identifiable medical & personal information to my insurance companies, managed care organizations and other federal programs as necessary to perform administrative functions.

Consent for Treatment

I authorize the health care provider staff of BioRenew to administer such care and treatment as medically indicated and is set forth in my developed plan of treatment. (NOTE: Persons under 18 years old must have legal guardian to be seen and receive services or written consent from the guardian.)

Health Insurance Portability and Accountability Act (HIPAA)

I certify that i am aware that certain disclosures to third parties, such as my insurance company, are required in order for BioRenew to submit for reimbursement for services. I authorize these disclosures as well as disclosures or communications with: Pharmacies, hospitals, and physicians. BioRenew may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. BioRenew may e-mail to my home or other alternative location any items that assist the practice in carrying out PTO, such as appointment reminder cards and patient statements.

Agreement to Pay

I acknowledge and agree that I am responsible and will pay for all regular charges (which are contained in a price list which is in effect on the dates of services rendered) for services and treatment provided to me, including any amount not paid by my insurance plan, to the extent legally permissible. I understand that I am responsible for any non-covered insurance services, deductibles and co-insurance.

I hereby agree that if BioRenew or its agents has agreed to bill my insurance or other third party carrier, it has agreed to do as a courtesy, and that BioRenew has the right, should BioRenew deem it advisable, to demand payment in full from me at any time prior to full payment from any insurance or third party carrier, unless BioRenew and my insurance company or third party carrier have agreed that I will not be billed.

I hereby acknowledge having been told that I may be billed by BioRenew and that this Outpatient Payment Agreement shall cover any and all providers accounts. If a delinquent account is referred for collection, I agree to pay the reasonable attorney's fees, court cost and/or collection agency fees referred for collection,. I agree to pay the reasonable attorney's fees, court cost and/or collection agency fees of 35% associated with the collection process.

I understand that there is a $25.00 returned check fee. I HAVE READ THIS AGREEMENT OR HAVE HAD IT READ TO ME. THE INFORMATION WHICH I HAVE PROVIDED IS ACCURATE, BY VOLUNTARILY SIGNING THIS AGREEMENT, I ACCEPT AND AGREE TO COMPLY WITH ITS TERMS.

I understand if I have any questions or need to change my payment arrangements, I should ask BioRenew personnel.

Family Member to whom information may be released:

Name	**Relationship**	**Phone Number**

Signature _____ **Date** _____

Patient

Signature _____ **Date** _____

Legal Guardian (if patient is a minor)