Consent to Treatment and Other Acknowledgments

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, medical services, or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by any healthcare provider assigned to my care, and I acknowledge and consent to the following:

PROCEDURES: During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physician(s), nurses, technicians, physician assistants, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.

NO GUARANTEE OF RESULTS: Optimum Health/Atlas Total Health physicians and healthcare professionals can not guarantee any specific result(s) of any examination, treatment, procedure or medical care. I release Optimum Health/Atlas Total Health, its physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of Optimum Health/Atlas Total Health or its employees.

PROVIDING ACCURATE INFORMATION: I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any condition or events which may impact medical decision-making.

INDEPENDENT CONTRACTORS: Optimum Health/Atlas Total Health may utilize independent contractors for office treatment/procedures. These include, but are not limited to, therapists, technicians, and consulting and referral physicians. Healthcare professionals that are independent contractors are not agents or employees of Optimum Health/Atlas Total Health and are responsible for their own actions. I understand that Optimum Health/Atlas Total Health shall not be liable for the acts or omissions of independent contractors. This Consent to Treatment also applies to any independent contractor utilized by my healthcare professional(s).

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS: I hereby expressly authorize Optimum Health/Atlas Total Health and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to Optimum Health/Atlas Total Health and all professionals (including independent contractors) providing for such care, and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to Optimum Health/Atlas Total Health and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.

PAYMENT FOR SERVICES: In return for services to be provided by Optimum Health/Atlas Total Health, I promise to pay for services rendered by Optimum Health/Atlas Total health to me or for my benefit. If the services I receive from Optimum Health/Atlas Total Health are covered by a third party payor, Optimum Health/Atlas Total Health may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third party payor determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. I acknowledge that Optimum Health/Atlas Total Health will attempt to obtain or confirm benefits and coverage information from my insurance company or other third party payer, but that this is not a guarantee of coverage or payment, nor does it release me from any payment obligation for the services that I receive. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are received.

AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS: I authorize and release Optimum Health/Atlas Total Health and its employees and agents to take photographs, videos, x-rays, and or other photographic, electronic or other images of me and to use them as may be medically appropriate. Such images may be used for educational or other purposes as necessary and appropriate. These images may be maintained as a permanent part of my medical record. I understand and acknowledge that Optimum Health/Atlas Total Health may use cameras for security and patient monitoring, and patient confidentiality will be maintained for all such images. However, we do not allow videotaping, recording or photography in the office without the healthcare professional's permission.

VALUABLES: Optimum Health/Atlas Total Health assumes no responsibility for, and I hereby release Optimum Health/Atlas Total Health from liability for, loss or damage to any of my personal property while on the premises and/or receiving treatment.

EMAIL: I understand that emails sent to Optimum Health/Atlas Total Health may be considered as part of my medical records. I also understand that emails sent to Optimum Health/Atlas Total Health may be read by staff that is covering for another individual or by individuals that need to see the email for treatment purposes.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits). A copy of this document may be utilized the same as the original.

_____	_____	_____
Patient Name (printed)	Patient Signature	Date
_____	_____	_____
Parent/Guardian Name (printed)	Parent/Guardian Signature	Date