CONSENT FOR MEDICAL TREATMENT:

I consent to an medical treatment rendered to me or my minor dependent under the general and special instructions of the physician in charge. In the event an employee is accidentally exposed to my blood/body fluids, I consent to testing of my blood as deemed necessary by the physician. I acknowledge that no guarantee or warranty has been made by the physician as to the results of any treatment which may be given or performed. I also acknowledge that I am totally responsible to comply with the physician instruction regarding the necessity for follow-up care. I alleviate the physician and Jason B. Kaster, D.C. of any and all liability if I do not comply with the directive givens.

ASSIGN BENEFITS & AUTHORIZE TO BILL/CORRECT/ARBITRATE/APPEAL on my behalf:

I authorize the payment of any insurance benefits due me or my dependents, **including Medicare** if applicable, to be made directly to Jason B. Kaster, D.C.. I understand that within the authorization to bill, ARBITRATE or APPEAL my insurance **including Medicare** that the diagnosis (which is confidential) must be included.

RELEASE OF MEDICAL RECORDS FOR THE PURPOSE OF OBTAINING RELATED PAYMENT:

I authorize the physician or his/her authorize representative to release all related medical information contained in my medical record. I understand that the records to be disclosed may also include specific confidential information as defined in F.S. 381.609, such as HIV TEST AND RESULTS, ALCOHOL/SUBSTANCE ABUSE, PSYCHIATRIC EVALUATIONS, but not limited thereto. Jason B. Kaster, D.C. are hereby released from all legal liability that may arise from the release of this information by the patient and/or family.

PAYMENT POLICY:

Patients ***without insurance are expected to pay the services in full on the day service is rendered.*** Patients ***with insurance are required to pay their deductible, co-pay, and/or 20% on the day service is rendered.***

MEDICARE DEDUCTIBLE AND 20% IS PRIMARILY THE PATIENTS RESPONSIBILITY:

Jason B. Kaster, D.C. will **bill the supplement insurance** *immediately* after the Medicare payment is received. We include the Medicare payment information and ***bill it to the address you provided to us***. The patient is responsible to pursue his/her Insurance to see that they pay promptly. Within thirty (30) days of the Medicare payment, we will begin to look to the patient for the balance. Jason B. Kaster, D.C. does not accept "assignment" of most supplements, the patient should expect payment direct.

RETURNED CHECK CHARGE POLICY:

An additional minimum twenty-five dollar ($25.00) charge for returned check/s will be my responsibility to pay in cash or with a guaranteed method of payment.

FINANCIAL AGREEMENT:

Payment for all medical services are due when service is rendered. When my insurance payment is ***accepted*** this ***DOES NOT WAIVE MY RESPONSIBILITY*** to pay the "patient responsibility" of my claim. **Jason B. Kaster, D.C. cannot waive co-payments, it is a violation under both Federal regulations and State insurance legislation.** I further understand I am liable for up to 1-1/2% finance charge (18% annually) should my outstanding balances not be paid within 60 days. I accept my responsibility to pay the legal interest and collection fees along with any related reasonable attorney fees as may be necessary to effect collection of this note.

I agree to be responsible to pay any charges non-covered by my insurance for which I have signed an Advanced Beneficiary Notice.

_____ _____/_____/_____

LEGAL AGE PATIENT -OR- RESPONSIBLE PARTY SIGNATURE DATE