Personalized
Lifestyle Medicine Center
by Metagenics

AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/PRIVACY NOTICE/PATIENT RIGHTS AND RESPONSIBILITIES/ NON-DISCRIMINATION NOTICE

_____ **CONSENT FOR TREATMENT:** By this document, I do hereby request and authorize Personalized Lifestyle Medicine Center by Metagenics (PLMC), its centers and providers including physicians, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgement of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures.

_____ **RECEIPT OF PRIVACY NOTICE:** I acknowledge receipt of the Notice of Privacy Practices for Personalized Lifestyle Medicine Center by Metagenics on or after October 15, 2019.

_____ **INSURANCE AUTHORIZATION AND ASSIGNMENT:** I request that payment of authorized benefits is made on my behalf directly to the PLMC provider of service(s) furnished to me. I authorize PLMC to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to PLMC. I hereby authorize that photocopies of this form to be valid as the original.

_____ **PAYMENT GUARANTEE:** I do hereby guarantee payment of all fees and charges related to all services, supplements, and durable goods provided to me through PLMC and its providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a PLMC billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with PLMC's approval. I understand that appropriate collection measures may be initiated and that I may be liable for collection fees incurred in the collection of said account.

_____ **ELECTRONIC PRESCRIBING:** I understand that PLMC may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my PLMC providers and my pharmacy. I have been informed and understand that PLMC providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my PLMC providers to see this health information.

_____ **PATIENT RIGHTS AND RESPONSIBILITIES:** I acknowledge receipt of the Notice of Patients' Rights and Responsibilities for Personalized Lifestyle Medicine Center by Metagenics.

_____ **NOTICE OF NON-DISCRIMINATION:** I acknowledge receipt of the Notice of Non-Discrimination for the Personalized Lifestyle Medicine Center by Metagenics.

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Signature of Patient or Parent/Legal Guardian/Authorized Representative	Relationship to Patient (If Applicable)
______________________________	______________________________
Witness to Signature	Date of Signing