Sun Health WELLNESS

Client Consent and Acknowledgement

Name: _____ Date of Birth:_____

Please read and initial each section:

_____ **Financial Responsibility**: I do hereby guarantee payment of therapy services to Sun Health Center for Health & Wellbeing (CHW). I understand that I am responsible for payment of my account and the CHW does not accept responsibility for negotiating a settlement on a disputed claim. As a courtesy, CHW will bill my insurance. I understand that co-payments are due when services are rendered. Any balance, after the insurance payment has been received, is due and payable upon receipt. In the event this account is placed with an attorney or collection agency for collection, the undersigned agrees to pay reasonable attorney's fees, legal expenses and lawful collection costs in addition to all other sums due hereunder.

_____ **Consent for Consultation**: I hereby consent to the consultation services of CHW staff.

_____ **Authorization for Release of Information**: The CHW is hereby authorized to furnish and release, in accordance with the CHW policy and HIPAA guidelines, such professional and clinical information as may be necessary for the completion of my medical claims. The CHW is hereby released from all legal liability that may arise from the release of said information.

_____ **Assignments and Authorization to Pay Insurance Benefits**: I hereby assign and authorize payment directly to Sun Health/CHW, herein specified and otherwise payable directly to me, but not to exceed the CHW's regular charges for this period of service. I understand I am responsible to the services charges not covered or paid by my insurance.

_____**Assignments and Authorization to Bill Medicare**: I hereby assign and authorized payment directly to Sun Health/CHW, herein specified and otherwise payable to me, but not exceed CHW's regular charges for this period treatment. I understand I am financially responsible for any charges not covered under Medicare Part B coverage.

_____**Client Rights & Responsibilities**: I have received a copy of CHW's Client Rights & Responsibilities.

_____ **Notice of Privacy Practices (HIPAA)**: I have received a copy of CHW's Notice of Privacy Practices.

Client and/or Responsible Party agree and have received a copy of this document.

_____ Date:_____
Client Signature

_____ Date:_____
Responsible Party Signature (if applicable)

_____ Date:_____
Facility Witness

14719 W. Grand Avenue
Surprise, AZ 85374

SunHealthWellness.org

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