Thank you for choosing Hyatt Hydration and Wellness Clinic. Our main concern is that you receive high quality care. In order to prevent any misunderstanding and to serve you better, we ask that all patients read and understand our policies. If you have any questions or concerns, please do not hesitate to ask.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Hyatt Hydration and Wellness Clinic to furnish medical care and treatment considered necessary and proper in the diagnosing and/or treating a physical condition.

FINANCIAL POLICY STATEMENT

I understand that Hyatt Hydration and Wellness Clinic collects payments at the time services are provided. I am aware that at this time Hyatt Hydration and Wellness Clinic does not accept insurance. I agree that I am responsible for all payments at time of service. I understand that it is my responsibility for requesting any reimbursements from my insurance company. Hyatt Hydration and Wellness Clinic will provide any documentation that is needed with my request.

PATIENT PRIVACY PRACTICES

I authorize Hyatt Hydration and Wellness Clinic to release any medical or financial information to a medical care provider who is performing medical care of a diagnostic test on behalf of or at the request of the health care provider of Hyatt Hydration and Wellness Clinic. I Hyatt Hydration and Wellness Clinic its agencies and designees, to utilize any information in my medical record for quality assurance and risk management activities. **By state law**, you must be advised that the information authorized for release may include records which may indicate the presence of a communicable disease which includes but is not limited to diseases such as hepatitis, human immunodeficiency virus (HIV) acquired immune deficiency syndrome (AIDS), and syphilis. I hereby authorize Hyatt Hydration and Wellness Clinic to release medical information obtained in the course of my evaluation and treatment to my employer and/or employers representative (only in the case of job related injury or illness), my primary care physician and my insurance carrier.

MEDICATION CONSENT

I give permission for Hyatt Hydration and Wellness Clinic to access my pharmacy benefits data electronically. This consent will enable Hyatt Hydration and Wellness Clinic to determine the pharmacy benefits and drug co pays for my health plan, check whether a prescribed medication is covered (in formulary) under my plan, display therapeutic alternatives with preference rank (if available) within a drug class for medications, determine if my health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies, and download a historic list of all medications prescribed for me by any provider. We ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers.

Signature of Patient/Guardian/Responsible Party:_____

Date: _____

There is no expiration date to this document.