





# Therapy Consent Form

I \_\_\_\_\_ hereby acknowledge that I have the right as a patient to either accept or decline any therapies recommended to me by the health care providers of Preventive Medicine Anti-Aging and Chelation Therapy, and the decisions to accept or decline therapies is at my own free will. In the case that I receive a prescription I acknowledge that I have the option to have my prescription called in, faxed, or have a hand written prescription.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Guardian Signature (If Applicable): \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

In order to serve our patients better, we have instituted a cancellation policy. If you cannot make it to your appointment please contact us 24 hours in advance to cancel your appointment. **If you DO NOT cancel 24 hours in advance you will be charged a no-show fee of \$50.00.**

## Release of Information

Please list individuals who have permission to receive information on your behalf:

1. Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_
2. Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_
3. Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS  
AS WELL AS AN  
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA  
REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Preventive Medicine Anti-Aging and Chelation Therapy, Robert A. Burkich MD, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

X \_\_\_\_\_  
(patient signature)

\_\_\_\_\_  
(please print patient name)

X \_\_\_\_\_  
(signature of Guardian if applicable)