Kinwell

AUTHORIZATION FOR TREATMENT / FINANCIAL RESPONSIBILITY STATEMENT

Clinic:	Patient Name:	DOB:

TO THE PATIENT:

Welcome to Kinwell,

We support your right to make decisions about the healthcare treatment you receive. By signing this document, you're giving Kinwell permission to conduct reasonable and necessary medical examinations, testing, and treatment. You have the right to discuss these procedures with your medical team to better understand their purpose, potential risks, and benefits. We encourage you to ask questions, and we support your right to decide whether or not to undergo any recommended procedures.

- I have read, or have had explained to me, the below Authorization for Treatment and Financial Responsibility Statement. I understand the contents and by signing, I agree to be legally bound by this document.
- I have read, or have had explained to me, the below Patient Rights and Responsibilities.
- By signing this document electronically, I certify I am of lawful age and legally competent to consent. If signing for another, I certify that I have legal authority to sign on their behalf.

PATIENT / PERSONAL REPRESENTATIVE SIGNATURE:

DATE:

AUTHORIZATION FOR TREATMENT: I hereby consent to the provision of care, diagnosis and/or treatment by a Kinwell Clinician (MD/DO/ARNP/PA) or their designee to administer any treatment including medication(s) or vaccine(s) as deemed necessary or advisable in the diagnosis and treatment of any conditions related to me or the patient (named above). This authorization is valid and in effect until such time I withdraw it in writing or in person.

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ASSIGNMENT OF BENEFITS AND PAYMENT TERMS

MEDICARE AND OTHER GOVERNMENT PROGRAMS (AS APPLICABLE): If I qualify for benefits under Medicare or other government program that is accepted by Kinwell, I authorize these programs to make payment directly to Kinwell for my care. I also authorize Kinwell to release all relevant information about me and my health care necessary to receive payment to the applicable government program(s). I am responsible to pay any deductible and/or co-insurance under such program(s).

INSURANCE: If I qualify for benefits from any insurance company(s), I assign those benefits to Kinwell to pay for care provided. I also authorize Kinwell to release all relevant information about me and my health care to the company(s) necessary to receive payment. I am responsible for any co-payments and/or deductible required under my insurance plan(s).

PAYMENT TERMS: Kinwell has agreed to accept assignment of benefits from governmental health care programs and certain insurance companies. I remain personally responsible for payment in full for billed charges, unless otherwise required by law.

FINANCIAL ASSISTANCE: If I am unable to meet the financial requirements for the services rendered, I am aware that I may apply for financial assistance or establish a payment plan by contacting a Kinwell financial representative.

RIGHT TO REVOKE AUTHORIZATION: I have the right to cancel my assignment or my authorization for Kinwell to release information about me and my health to government program(s) and/or insurance company(s). My revocation must be in writing and will be effective when it is received by Kinwell.

USE AND DISCLOSURE OF INFORMATION: The way Kinwell may use information about me is explained in the “Notice of Privacy Practices”.

FINANCIAL RESPONSIBILITY STATEMENT: I accept financial responsibility for all treatment provided.

- I authorize Kinwell to charge my credit card for agreed upon charges, at an agreed upon frequency and timing for any payment plans initiated, and to credit back to the card any refunds. I understand that my information will be saved to file for future transactions on my account and that this authorization will remain in effect until cancelled by me, which may be done at any time by contacting Kinwell.
- I understand Kinwell will make inquiries regarding insurance coverage and my financial responsibility from third party payors or financial references. In addition, I approve those payors and/or references to release information to Kinwell.
- I understand Kinwell and its Affiliates (collectively "Kinwell") do not discriminate on the basis of race, religion, color, national origin, sex, age, marital status, veteran status, gender, gender identity or expression, sexual orientation, genetic information, disability, or any other protected category under federal, state, or local law.
- The balance is due 30 days from the date of billing. If I need financial assistance or wish to establish a payment plan, I can contact a Kinwell financial representative. Should this account be assigned to an attorney or collection agency, I will be obligated to pay associated costs. I request direct payment of benefits to Kinwell for any clinical services rendered.

Patient Rights & Responsibilities

ACCESS TO CARE - You have a right to access health care, including emergency assessment and treatment, and timely referral to specialty care.

RESPECT - You have a right to be shown respect, dignity, and consideration by all Kinwell teammates.

COMMUNICATION - You have a right to be informed about services, treatment, options, and costs in a clear and open way. You have the right to be notified of any unanticipated events related to your care.

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PARTICIPATION - You have a right to be included in decisions and choices about your care, including the right to decline treatment. You have the right to choose or change your clinician.

PRIVACY - You have a right to privacy and confidentiality of your personal information, and to be notified of any disclosures made.

GRIEVANCES - You have a right to comment on your care and to have your concerns addressed in a timely manner.

PARENTAL RIGHTS - You can exercise your rights as a parent or guardian of a child.

All Patients, to the Extent Capable, Have the Responsibility To:

SAFETY - Tell us of your safety concerns.

RESPECT - Consider the wellbeing and rights of others, including Kinwell teammates and other patients.

COMMUNICATION - Provide complete and accurate information regarding your medical history, health concerns, medications, over-the-counter products, dietary supplements, allergies/sensitivities, and to ask questions.

PARTICIPATION - Follow your mutually accepted treatment, collaborate with clinicians, and participate where able.

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POWER OF ATTORNEY / GUARDIANSHIP - Please inform a Kinwell teammate if you have a current Power of Attorney for any health or financial matters, or if you are subject to a guardianship order.

FINANCIAL - You should provide accurate insurance information and promptly pay the fees not covered by your insurance.