

Consent to Treatment and Financial Agreement

Complete and sign before the first visit

Patient name: _____	Date of birth: _____
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1. Consent to evaluation and treatment

I voluntarily consent to evaluation and medically appropriate care provided by OptimalLife Primary Care and its authorized clinical staff. Care may include history-taking, physical examination, preventive services, diagnostic testing, treatment, referrals, prescriptions, and routine in-office procedures when clinically appropriate. I understand that no specific result can be guaranteed and that I may ask questions or decline a recommended service. Procedures requiring separate informed consent will be discussed separately when applicable.

2. Insurance authorization and assignment of benefits

I authorize the practice to submit claims and information reasonably necessary for payment, care coordination, utilization review, and health care operations. I assign directly to Optimal Life LLC benefits payable for covered services, to the extent permitted by my plan and law. I authorize payment to the practice and understand that this assignment does not eliminate my financial responsibility. I authorize the practice to verify eligibility and benefits and to communicate with my insurer about claims.

3. Patient financial responsibility

I am responsible for copayments, coinsurance, deductibles, noncovered services, and charges not paid by my insurer, except where prohibited by contract or law. Insurance verification is not a guarantee of payment. I agree to provide accurate, current insurance information and promptly notify the practice of changes. Amounts due at the time of service may be collected before or after the visit. I may request information about expected charges and available payment arrangements.

4. Referrals, prior authorization, and external services

I understand that I am responsible for knowing plan requirements, including referral, network, and prior-authorization rules. The practice will assist when appropriate but cannot guarantee approval or coverage. Laboratories, imaging centers, specialists, hospitals, and other outside entities bill separately and are responsible for their own network participation and charges.

5. Prescription and clinical information exchange

I authorize the practice to obtain and review medication history, prescription-monitoring information, laboratory results, imaging reports, and other information permitted by law for treatment, payment, and health care operations. Specially protected records will be handled according to applicable law and any required authorization.

6. Acknowledgment

I have had an opportunity to read this form and ask questions. I understand that this consent remains effective while I receive care from the practice unless I revoke it in writing, except to the extent the practice has already relied on it or the law allows action without consent.

Patient/authorized representative signature: _____	Date: _____
Printed name: _____	Relationship: _____
Practice representative/witness: _____	Date: _____

For office use: ☐ Identity verified ☐ Insurance card received ☐ Photo identification received