CONSENT AND FINANCIAL AGREEMENT

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plan to **Acadia Total Health, LLC** or its designee. This agreement will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. I understand there is a $25 charge for all NSF Checks.

CONSENT TO TREATMENT

I hereby voluntarily and knowingly consent to and authorize my physician or other health care professional, or his or her designee other members of **Acadia Total Health, LLC** (hereinafter the "Clinic") professional staff and its employees, either severally or collectively, to carry out or cause to be carried out, diagnostic testing, examination and/or medical treatment, including any and all procedures which my physician or his or her designee in her best judgement, may deem proper for my health care, I acknowledge that no guarantees have been made as to the result of treatments or examinations. I hereby grant permission for the Clinic to view external prescription history and/or external health information documents and incorporate these into my medical record.

WAIVER OF LIABILITY FOR PROSESSIONS:

I hereby agree, and it is understood that the Clinic is not responsible for the damage, loss and/or theft of any personal property I may retain in my possession while a patient.

AUTHORIZATION FOR RELEASE OF INFORMATION:

For purposes of expediting payment of my account and processing of benefit claims resulting from my visit and for the assessment of damage claims or potential claims against the Clinic, the hereinafter listed Health Care Providers , my attending or consulting physicians and their insurers. I hereby expressly waive my rights and privilege under Louisiana Revised Statute 13:3734 (see Statute) and authorize the release of my patient information directly to my insurer(s), worker's compensation carrier or other medical compensation benefit provider(s) as well as to insurer(s) of Clinic, to my attending physician or their insurers, or the legal representatives of any of them as well as to any collection agency or attorney if my account is not paid within a reasonable time. This authorization includes all medical, administrative and financial records, information and transaction, including all personal and insurance data, photographs, drawings or other graphic representations contained therein as well as the "Communication" of such information as defined by said Statute regardless of whether such payment information is in oral, written or printed form or is necessary stored on microfilm, magnetic tapes or other audio and/or visual media. I further authorize and agree to be bound by, the use of carbon or photostatic reproductions of this assignment.

INSURANCE PRE-CERTIFICATION

I hereby expressly understand I am responsible for the notification of my insurance company to obtain authorization before service is rendered. I understand if this is no done, insurance benefits may be reduced.

I certify that I have read the foregoing legal instrument and that I understand each o the provisions contained therein. I agree that the terms of this agreement are binding upon me until the end of the calendar year unless I expressively revoke any or all of them in writing directed to and received by the Clinic