Michelle Maier, FNP
3123 North 14th Street
Bismarck, North Dakota 58503
Tel: 701.751.7244 Fax: 701.751.3071
Embrace Wellness, PLLC

Patient Name: ____

AUTHORIZATION FOR EVALUATION/TREATMENT - I hereby authorize the professional in charge of the above named patient to evaluate and administer treatment necessary or advisable.

RELEASE OF INFORMATION TO HEALTH CARE PROVIDERS – Michelle Maier, FNP is authorized to release all or part of the patient records to healthcare professionals (i.e. physicians, hospitals, agencies, nursing home providers, etc) involved in provision of direct emergency care. Michelle Maier, FNP is further authorized to release such information as may be necessary or required for statistical reporting and hospital accreditation purposes or as required by law.

LIMITS OF CONFIDENTIALITY - I understand the limits of confidentiality as outlined on this form.

RELEASE OF INFORMATION FOR INSURANCE CLAIMS – Michelle Maier, FNP Family Nurse Practitioner is authorized to release all or part of the patient's medical record to any person or corporation which is or may be liable for any part of the clinics charges, including but not limited to, hospital or medical services companies, insurers, compensation carriers or government agencies. It is understood that photo copy of this form is a valid authorization for release.

ASSIGNMENT OF BENEFITS - I authorize payment of any insurance benefits arising from policies insuring the patient or any party liable to the patient, directly to Michelle Maier, FNP. I understand that I am financially responsible for any charges not covered by this agreement.

FINANCIAL RESPONSIBILITY- In consideration of the services rendered to the patient by the provider, the undersigned guarantees that payment of any amount due. I have read the statement of financial understanding and I assume financial responsibility for the expenses of the above named patient.

BILLING POLICIES - All information requested is necessary for the proper processing of claims and to speed up the billing process. Michelle Maier, FNP will not accept the responsibility for collection of insurance claims or negotiate settlements in disputed claims; you the patient are responsible for the bill. If problems arise in the processing of these claims we will provide any assistance possible.

MEDICAL SIGNATURE ON FILE - I authorize payment of Medicare benefits to be made to Michelle Maier, FNP for any service furnished to me by the provider. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services.

CERTIFICATION - I hereby certify that I have read each of the above statements, have had each item explained to me by my satisfaction, have received a copy of if requested; and being the patient or being duly authorized by the patient, do agree and accepts its terms.

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Signature/Date