# Apothicor LLC Patient Consent & Statement of Financial Responsibility Form

## Acknowledgment of Revocation

I acknowledge that I am of sound mental capacity and fully capable of reading and comprehending this Patient Consent and Statement of Financial Responsibility Form. Nothing is currently preventing me from reading or understanding the terms of this Patient Consent and Statement of Financial Responsibility.

I hereby authorize the providers at Apothicor Wellness to make recommendations regarding my healthcare and to communicate those recommendations to me and to my other healthcare providers. The providers at Apothicor Wellness have advised me of the possible health risks associated with their recommendations. I understand those risks and voluntarily choose to move forward with the implementation of Apothicor Wellness' recommendations.

As such, in light of my understanding of the possible health risks and decision to voluntarily move forward with the implementation of Apothicor Wellness' recommendations, I hereby waive, release, and hold harmless Apothicor Wellness LLC from any and all claims, injuries, or damages of any nature which arise in connection with Apothicor Wellness' recommendations, should they occur now or at any time in the future. I understand that I have the right to deny recommendations made to me or to revoke authorization of Apothicor Wellness LLC to make such recommendations to my healthcare providers by informing Apothicor LLC. If I do revoke this authorization in the future, I acknowledge and understand that such revocation will not revoke or rescind any actions or recommendations which were previously made or acted upon at a time when this authorization was in full effect.

I acknowledge that a copy of my medical record and treatment documentation may be sent to any of my healthcare providers for purposes of, among other things, continuity of care and treatment. Pursuant to this Patient Consent and Statement of Financial Responsibility, I hereby authorize Apothicor Wellness to contact my healthcare provider(s) in order to obtain medical information and discuss aspects

of my treatment and progress in controlling my health condition and/or for a recommendation for further evaluation.

If the individual receiving treatment is a minor or has a caregiver whom medical decisions are authorized by, please indicate below:

- ☐ The individual is a minor or has a caregiver who authorizes medical decisions

## Authorization Request

I understand that authorization for an individual other than myself will require valid authorization (ex. Power of attorney) signed by all required parties and delivered to Apothicor LLC.

## Statement of Financial Responsibility

Where applicable, I understand that I am solely financially responsible for all charges, whether or not they are covered by my insurance carrier or entitlement plan, including federal healthcare beneficiaries (eg. Medicare, Medicaid etc.) and acknowledge that payment for all services rendered is due at the time of service. I further acknowledge that it is my sole responsibility to seek reimbursement from my insurance carrier for services rendered by Apothicor Wellness.

If Apothicor Wellness has an agreement with my health plan or insurer, I understand that I am responsible for paying any co-payment or deductible amount today, at the time of service. I understand that I may be billed for any additional deductible, co-insurance or non-covered services deemed my responsibility by my insurance carrier or entitlement plan.

I acknowledge and understand that I am not required to purchase any recommended or prescribed items, products or services from Apothicor LLC or affiliates.

Please note, eligible beneficiaries of contracted employers and/or health plan groups are not required to pay for services per contract agreements.

_____ __/__/____
(Name of patient) (Date of birth)

_____ __/__/____
(Signature of patient or authorized representative) (Today's Date)

_____
(Relationship to patient)