Consent to Treatment and Financial Responsibility Policy

Consent to Care: I hereby voluntarily consent to Psychiatric treatment by New Image Wellness and/or associates or designees as necessary in their judgment and as have been discussed with me, which may include Medical Evaluation, Psychotherapy, and Medical management.

Assignment of Benefits: I hereby authorize direct payment to New Image Wellness's Professional Corporation of insurance payments otherwise payable to me, but not to exceed physician charges. In the event that my insurance company does not approve any or all of my physician or associated medical charges, I hereby give New Image Wellness my consent to pursue all available appeal processes.

Information: information from my medical record may be used for educational and research purposes, internal performance improvement, or scientific publications. This permission is given on the condition that neither my name nor my identity will be revealed in connection with these activities.

Lab Studies: Lab studies collected in our office are submitted to specific labs if required by your insurance company. It is the patient's responsibility to inform our office if your insurance company requires use of a specific lab, otherwise the patient is responsible for lab services not covered by your insurance company.

Governing Law: I agree that all questions, issues, and/or claims arising from my care or treatment by New Image Wellness, its agents, employees, and/or its physicians shall be governed by and construed in accordance with the laws of the state of New Jersey and the sole Proper venue and jurisdiction regarding any such question, issue, or claim shall be in the Superior Court of New Jersey.

Release of Information: I understand New Image Wellness may disclose all or any part of my medical record to any person or corporation which is or may be liable under a contract to New Image Wellness or to the patient or to a family member or employer of the patient for all or part of the physician's charge, including, but not limited to physician or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or my employer.

I have read this form, all information has been fully explained to me, and I certify and acknowledge that I understand the contents of the information. A copy of Office Procedures and policy of New Image Wellness was given to me.

Signature:____Date:________Time: ______

Witness Signature: ____Date:________Time: ______

Signature, Guarantor of Payment:____Date:________Time: ______

Signature, Responsible Party: Relationship:__________________________Date:________Time: ______

P 856.983.4940 *Daytime*
P 856.396.7200 *Evening/Weekends*
F 856.983.3408

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