General Consent: I consent to evaluation and treatment. I understand that multiple treatment options exist, with varied risks and benefits, including drugs and surgery. I may choose not to receive treatment. If the risks and benefits of a proposed treatment/intervention are not clear, further information may be requested by me. I give full consent to receiving treatment, understanding that there are potential risks. Information within the patient chart is confidential. I understand that all requests for release of my records must be in writing and signed by me. I understand that I have a responsibility to communicate honestly to the Integrative Medicine health care team and notify them of any changes in my health status. If my condition is determined to be medically complex, or felt could benefit with physician management, with the primary goal of improving clinical outcomes and efficacy, I give full and unconditional consent that Paula Castro, MD manage, supervise or delegate care and bill me or my insurance for professional services.

Financial Consent: I understand I am financially responsible for all charges incurred by me, whether or not my insurance pays. I assign my insurance benefits to Integrative Medicine Center/Paula Castro, MD. Any overpayment will be promptly refunded. I authorize Integrative Medicine Center/Paula Castro, MD to release protected health information to secure payment. Accounts over 90 days past due are subject to a monthly finance charge of 1.5%, 18% annually and collection costs.

Release of Records: I authorize ______________________ to release all health records necessary for my treatment and/or evaluation to Integrative Medicine Center/Paula Castro, MD.

Patient Signature ____ Date ____/____/_____

Responsible Part's Signature (If patient is a minor)______________________ Date ___ /_____/_____