AUTHORIZATION AND RELEASE FORM

Authorization for treatment: I voluntarily consent to the administration and cost of medical, nursing, chiropractic and surgical procedures for myself or my dependent.
Authorization for use of e-mail/cell phone: I voluntarily consent to the use of my personal email and/or cellular phone via voice or text to receive newsletters, marketing campaigns, or notifications. This is NOT to be used for my private medical records or health information.
Assignment of insurance benefits: I authorize payment directly to OneCare Health- Advanced Practice Health & Wellness Corp., its owners, affiliates and or providers for all benefits otherwise payable to me.
Guarantee of payment: I understand that I am financially responsible and agree to pay all charges that are not paid or billed to insurance or any other third-party payer. I understand that I must pay in full today for all services rendered. I also understand that if my insurance is accepted, I must pay all applicable insurance co-pays, coinsurance and deductibles today. If you become delinquent on payments to OneCare Health- Advanced Practice Health & Wellness Corp., we may forward your bill to collections. For those who submit a claim independently to their carrier we can provide an itemized bill/invoice for services at the request of the patient via writing. However, it is to the discretion of the insurance carrier to accept/cover claim(s). OneCare Health- Advanced Practice Health & Wellness Corp., will not be responsible for uncovered/denied claims from insured/carriers.
Release of records: I authorize OneCare Health- Advanced Practice Health & Wellness Corp., to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for the quality management, utilization review, transfer, and follow up purposes.
Receipt of privacy practice (terms and conditions): I acknowledge I have received and read the notice of privacy practices of OneCare Health- Advanced Practice Health & Wellness Corp.,which includes the NYS patient bill of rights, and the terms and conditions. I understand that a copy of this agreement may be used with the same effectiveness as the original.
Release for photo/video/social media/marketing/ PR: I hereby grant OneCare Health- Advanced Practice Health & Wellness Corp., the permission to use my likeness in a photograph, video, or other digital media in any and all of its publications, including web-based publications, social media accounts without payment or other consideration. I understand and agree that all photos will become the property of OneCare Health- Advanced Practice Health & Wellness Corp., and will not be returned. I hereby irrevocably authorize OneCare Health- Advanced Practice Health & Wellness Corp., to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo/video. I hereby hold harmless, release, and forever discharge OneCare Health- Advanced Practice Health & Wellness Corp., from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

_____	_____	_____
Signature	**Print Name**	**Date**
Patient/Relative/Agent/Guardian	**Relationship, if other than patient**	