AVEDAMED®
Primary Care | Cardiology | Rheumatology

AvedaMed, LLC
2130 Millburn Ave, Ste A-4
Maplewood, NJ 07040
Phone: (973) 761-6111
Fax: (973) 761-6111
Info@AvedaMed.com
AvedaMed.com

CONSENT FOR MEDICAL SERVICES & FINANCIAL RESPONSIBILITY

I, _____ , *understand and agree that my below affixed signature* authorizes medical treatment and outlines my patient responsibilities regarding insurance billing and payment for services rendered by AvedaMed, LLC, and their affiliated providers and staff (hereinafter referred to as "Providers").

Consent for Medical Services: I voluntarily consent to undergo medical evaluations, diagnostic procedures, and treatments that are deemed necessary by my treating provider(s). I understand that I may decline or revoke consent for treatment at any time. I acknowledge that the Providers do not offer emergency medical services and that in the event of a medical emergency, I should seek care at the nearest hospital emergency department.

Prescription and Insurance Authorization: I authorize the Providers to access and review my prescription history and medication records for treatment and verification purposes. I affirm that the insurance information I provide is accurate and up to date. I agree to notify the practice promptly of any changes in my health insurance coverage or benefits.

Financial Responsibility: I agree to pay all required co-payments at the time of service, as well as any charges related to unmet deductibles or co-insurance. I am responsible for any unpaid costs due to inactive coverage or incorrect insurance information, payable within 60 days of notification. If my insurance provider sends payment directly to me, I will forward it to the Providers immediately. Any unpaid balance after 60 days may accrue interest up to 3% per annum, and if unpaid beyond 120 days, the Providers may initiate collections or legal actions.

Informed Consent: I confirm that I have had the opportunity to discuss the proposed treatment plan with my provider, including the **risks, benefits, and alternatives**, and that all questions have been answered to my satisfaction. I consent to proceed with care based on this understanding.

By signing below, I confirm that I fully understand and agree to the terms outlined herein, including the designation of my Authorized Representative, assignment of benefits, and granting of access to my insurance information.

Signature: _____ **Date:** _____