

SaJune Medical Center
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<http://www.sajune.com>

Consent for Purpose of Treatment, Payment and Healthcare Operations

I hereby request and consent to the performance of medical treatment and other procedures, within the scope of practice afforded by the licensed healthcare professionals and other clinical staff members of Sajune Medical Center ("Sajune"), on me or patient named below, for whom I am legally responsible.

I understand that any recommendations and care received at Sajune Medical Center are supportive only, and do not substitute for regular medical care. I understand that I must continue to see my regular treating healthcare providers as directed by them and take my regular medications as prescribed.

I understand that the methods of treatment provided by Sajune include, but are not limited to, Bio-identical hormone restoration, gynecology services, chiropractic care, acupuncture, Oriental and homeopathic medicine, weight loss, detoxification, nutritional restoration, facials and peels, massages, body treatments, hydrotherapy, spa services, hair removal, leg veins, mesotherapy, Botox cosmetic, Juvederm, Velasmoth, Fotofacial RF, dermal fillers, electrical stimulation, moxibustion, cupping, Tui-Na, Oriental herbs, teas and/or nutritional supplements to promote health and well-being, dietary and life style counseling. I understand that some of the herbs and supplements recommended by Sajune may have occasional side effects. I will immediately notify Sajune by telephone or in person of any side effects associated with my use of these herbs and/or supplements.

I understand that methods of treatment may involve insertion of various sized needles into different areas of my body, along with stimulation of these needles, either by hand or with an approved electrical device, and that there may be some discomfort and/or bruising during or following treatment.

I understand that I have the right to question any therapy proposed and/or provided by Sajune, and that all of my questions will be answered prior to receiving such treatment. I understand that I have **not** been and will not be given a guarantee of beneficial or specific results. I affirm that I have and/or will always, to the best of my ability, disclose my complete current and past medical history to Sajune. I understand this history is essential for Sajune to be able to assess and provide competent care and treatment to me. I understand that the treatment I receive from Sajune and its health care professionals is in large part based upon my disclosures to them.

I consent to the use or disclosure of my protected health information to Sajune for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bill, or to conduct healthcare operations. I understand that treatment by Sajune may be conditioned upon my authorization as evidenced by my signature on this Consent.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of Sajune. Sajune is not required to agree to any restrictions I may request. However, if Sajune agrees to any such restriction, the restriction is binding on Sajune.

I have the right to revoke this Consent in writing, at any time, except to the extent Sajune has taken action in reliance on this Consent.

My “protected health information” means health information including demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or a healthcare clearing house. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Sajune’s Notice of Privacy Practices prior to signing this Consent. The Notice of Privacy Practices describes my rights and Sajune’s duties with respect to my protected health information. The Notice of Privacy Practices describes the uses and disclosures of my protected health information that may occur during my treatment, payment of bills, or in the performance of healthcare operations. A copy of Sajune’s Notice to Privacy Practices has been provided to me. A copy of the Notice of Privacy Practices is also available at the reception desk.

Sajune reserves the right to change the privacy practices described in its Notice of Privacy Practices. I may obtain any such revised Notice of Privacy Practices by requesting a copy from Sajune’s staff or by requesting a copy be sent to me by mail.

Furthermore, I understand I am responsible for full payment of services at the time they are rendered and for any unpaid balances in the event of third party or insurance claims. I hereby acknowledge and accept full responsibility for any and all costs incurred.

By voluntarily signing below, I affirm that I have read or have had read to me, the above consent to treatment. I have been advised of the risks and benefits of the procedures provided to me, and I have had the opportunity to ask questions regarding each such procedure. I understand this Consent covers the entire course of treatment provided by Sajune for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient or Person legally empowered to execute this Consent for patient who is a minor or physically or mentally incompetent

Printed Name of Patient or Person legally empowered to execute this Consent for a patient who is a minor or physically or mentally incompetent

Date

Sajune Medical Center Representative