Patient Consent to Be Treated

Consent for Treatment:

I authorize Dr. Deborah Ginsburg and Healing Oceans Family Wellness to provide ongoing medical care, treatment, and procedures as needed. I understand that no guarantees can or will be made as to results of care, treatment, or medication prescribed and intend this consent to be continuing in nature even after a diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

Financial Agreement:

I acknowledge that I am financially responsible for all services provided whether or not paid for by insurance. I acknowledge that I have read and understand the Insurance & Billing page at healing-oceans.com/insurance-billing/, that all my questions have been answered, and that I agree to abide by these policies. **I have read and understand the in-between service fees for Dr. Ginsburg to do prescription refills, email correspondence, written letters, filled out forms and updating or writing a lab slip.**

Consent to Release of Information:

I authorize the release upon request to my insurance carriers or other reimbursing agencies any information necessary to secure the payment of benefits, thus releasing Healing Oceans Wellness, Dr. Deborah Ginsburg, staff, and its agents of any liability for furnishing such information.

Notice of Health Information Practices:

I have read the Policies at healing-oceans.com/policies/. If changes to the Polices page occur, I can view them online at any time.

I understand that Deborah Ginsburg, MD and Healing Oceans Family Wellness reserve the right to change the Privacy Practices. If changes to the Privacy Practices occur, I can view them online at any time at healing-oceans.com/policies/.

Acknowledgement of Practice Policies:

I acknowledge that I have read and understand the Office Policies of Dr. Deborah Ginsburg, all my questions have been answered and I agree to abide by these policies. I understand Healing Oceans does not work with patients who get testing done through Quest Diagnostics and will go to another lab such as Labcorp.

Patient Name: _____ Date: _____

Patient Signature: _____