AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND INFORMATION RELEASE

Please read and sign the form below.

By signing this form, I agree to the following: I hereby authorize the release of medical information including medical diagnosis, test results, and other medical professionals and institutions that I may be referred for treatment. I understand that this information will be used to review and determine if you qualify for medical cannabis certification. I authorize payment directly to Green Balance Health and Wellness for all medical cannabis certification and recertifications. I understand that I am financially responsible for all payments to Green Balance Health and Wellness as insurance does not cover for this service. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____

REQUEST FOR TREATMENT

I authorize Green Balance Health and Wellness to perform the necessary care ordered by my physicians. I understand that I have the right to be informed by my physicians of the nature of any proposed procedure and any available alternative methods or treatment, together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physician to provide accordingly to recognize standards of medical practice, and I acknowledge that the group and its personnel are responsible for providing this information.

Signature: _____ Date: _____

FINANCIAL AGREEMENT

Please read and sign the form below.

I understand that I'm directly responsible for all the charges incurred for medical service for myself and my dependents regardless of insurance coverage, I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of the billing date. I furthermore agree to pay legal interest, collection expense, and attorneys' fees incurred. **CANCELLATION POLICY**: If you have any inconvenience for showing to your appointment, please call us at least 24 hours before your appointment to reschedule. Our No-Show fee will be $50, and it must be paid before your next appointment. **RETURNED CHECKS**: Your account will be charged a $30 fee for each returned check.

FOLLOW UP VISITS: Follow up visits are crucial to maintaining the state mandate of creating and maintaining a bonafide relationship with your provider. Patients who miss the scheduled follow up will be charged $50 for the missed appointment. We request you come in 15 minutes early to account for traffic and to complete the required paperwork. If you are 15 minutes past your scheduled time, your provider may not be able to complete a full visit, or we will do our best to accommodate you and fit you in later in the day. If you cannot complete your visit you will be charged for the full visit and you will be required to book a new visit.

I will pay Green Balance **$200** for a physician evaluation and certification. _____ Initial
I will pay Green Balance **$100** for an existing patient re-certification. _____ Initials
Concierge patients will pay **$160** for a physician evaluation and certification _____Initial

Signature: _____ Date: _____