
1. I acknowledge that I am seeking wellness care and advice from Jan A. Soloy, ARNP. I give consent for examination and testing as indicated for preventive care as well as evaluation and treatment of symptoms of new health concerns and/or established problems or diagnoses.

Signature of Patient

Date

2. I have been informed that this practice is fee for service. I understand that even though a billing agent may assist me with insurance billing, I am responsible for the entire amount billed, regardless of amounts allowed by my insurance. I understand that Jan A. Soloy, ARNP is considered out of network for all insurance companies. I have been informed that Jan A Soloy, ARNP does not accept Medicare or Medicaid and I agree not to submit my bill to either of those agencies for reimbursement.

Signature of Patient

Date

3. I have been offered a copy of the Patient Privacy information as required by HIPAA.

Signature of Patient

Date

4. The above consents will be in effect for all visits in the year 2008.

Signature of Patient

Date

WITNESS _____ **DATE** _____

Patient Name _____ **MR#** _____