I hereby authorize US Pain & Spine Hospital to release any information acquired in the course of my examination or treatment for the purpose of determining eligibility for benefits and claims processing. Furthermore, I hereby authorize the payment directly to US Pain & Spine Hospital of the Medical / Surgical benefits, otherwise payable to me for the services rendered. I understand that **I am financially responsible for any and all charges not covered by this authorization and all outstanding balances maybe referred to collections. It is office policy that due to your insurance policy, you may be billed at a later date.** I agree a photographic copy is as valid as the original.

Initials: _____

ASSIGNMENT OF BENEFITS TO US PAIN & SPINE INSTITUTE

Medicare / Medicaid / Champus Patients ONLY: I hereby authorize Group Medical & Surgical Services to furnish to my physician any information obtained in the adjudication of any claims in regards to the services furnished to me under the Title XVII of the Social Security Act.

Initials: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE AND PATIENT BILL OF RIGHTS

By signing this form, you are agreeing that you have received a copy of our Notice of Privacy Practice, which describes how we use and disclose your health information and our Patient Bill of Rights notice, which outlines standards and use of your protected health information You have the right to refuse to sign this Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

Initials: _____

AUTHORIZATION TO VIEW MEDICATION LIST FROM E-PRESCRIBING SOFTWARE

I hereby authorize US Pain & Spine Hospital to view my medication profile available through e-prescribing software. I understand this list may not be comprehensive and is limited to the medications which have been prescribed to me electronically. It is my responsibility to provide my physician with a complete list of medications I am currently taking.

Initials: _____

CONSENT FOR TREATMENT

I voluntarily give my permission to the health care providers of US Pain & Spine Hospital, and other health care providers deemed necessary to provide medical services to me. I understand by signing this form I am authorizing them to treat me in the duration of my care with US Pain & Spine Hospital or until I withdraw my consent in writing.

Initials: _____

ACKNOWLEDGMENT OF MISSED APPOINTMENT AND RETURNED CHECK POLICY

I understand that US Pain & Spine Hospital has the right to charge a non-refundable fee of $25 for missed appointment(s) and $30 for checks returned unfunded.

Initials: _____

RECEIPT AND ACKNOWLEDGMENT OF THE ABOVE POLICIES / AUTHORIZATIONS / CONSENTS BY:

Patient, spouse, legal representative, or beneficiary (patient's spouse may authorize disclosure of patient's health information only when the health information is for the sole purpose of processing and application for health insurance, for enrollment in a health care service plan or an employee benefit plan, and where patient is to be an enrolled spouse or dependent under the policy or plan.)

Name of person completing form: _____ Date: _____

Signature of patient / authorized representative: _____ Relationship: _____
