Authorization to Release Information & Financial Policy

I hereby authorize US Pain & Spine Institute 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 Institute 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 patients will be subject to Urine Drug Screens at any/all office visits and these charges will be submitted to your insurance. Be aware 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 Service 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 acknowledgement and the reason why it was not obtained. **Initials:**

AUTHORIZATION TO VIEW MEDICATION LIST FROM E-PRESCRIBING SOFTWARE

I hereby authorize US Pain & Spine Institute to view my medication profile available thru 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 Institute, 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 Institute or until I withdraw my consent in writing. **Initials:**

ACKNOWLEDGEMENT OF MISSED APPOINTMENT AND RETURNED CHECK POLICY

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

RECEIPT AND ACKNOWLEDGEMENT 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 an 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:**_____