GENERAL CONSENT FOR MEDICAL TREATMENT AND ASSIGNMENT OF BENEFITS

GENERAL CONSENT FOR MEDICAL TREATMENT

In advance of any treatment or procedure(s), I authorize the physicians and designees of Midwest Pain & Spine to treat and/or perform procedure(s) that may include a routine diagnostic exam, radiological testing, laboratory procedures, and medication administration.

MEDICARE AUTHORIZATION

I request payment of authorized Medicare benefits be made directly to Midwest Pain & Spine for any services rendered to me, including physician charges. I understand that I am responsible for any services not covered by Medicare, and any applicable deductible or coinsurance amounts.

ASSIGNMENT OF BENEFITS

I assign and authorize payment for any and all services rendered directly to Midwest Pain & Spine from my insurance company or third party payor including, but not limited to, Medicare, Medicaid, commercial health insurance, automobile no-fault insurance, and workers disability compensation insurance. In consideration of the professional services provided or to be provided to me, I agree to pay all charges not covered by my insurance company or any applicable health benefit including, but not limited to, deductibles, co-payments, non-covered services. I understand that it is my personal responsibility to pay Midwest Pain & Spine all charges for services rendered despite of any disputes or disagreements between me and my insurance company.

PAYMENT GUARANTEE

Midwest Pain & Spine is committed to providing you, our patient with the highest level of patient care. Charges for services in our practice are within the “usual and customary” rates for our area.

All professional services rendered are charged to the patient or financially responsible party. As a courtesy to you, Midwest Pain & Spine will file all claims to your insurance company. All services rendered must be paid in full at the time of service, until your deductible has been satisfied. If you do not have a deductible, or it has been met, you must pay all “co-payments” or percentages as dictated by your insurance carrier. If you have met your deductible with another provider, documentation must be provided. If you do not have insurance, you must pay in full at the time of service, unless prior arrangements have been made.

Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 60 days, you will be responsible for the remaining charges. We will continue to assist you in resolving any outstanding balance.

I understand and agree that I am solely responsible for all charges to my account. I agree to pay all collection costs, returned check fees, attorney fees and court costs incurred by Midwest Pain & Spine in the collection of all charges due.

RELEASE OF INFORMATION

I understand that the confidentiality of all medical records will be protected to the full extent of the law. I authorize Midwest Pain & Spine to release all information from my medical record to:

1) Payors, organizations or insurance companies which are responsible, in whole or in part, for obtaining insurance benefits for me, for billing and/or paying my physician(s) bill, and for filing appeals of denial of benefits, so that the physician may be paid for the services provided to me
2) Independent auditors or review agencies retained by any third party payor and insurer to analyze the charges for services rendered to me.

The Midwest Pain & Spine Notice of Privacy Practices provides information about how protected health information about me (the patient) including information about human immunodeficiency virus (HIV), AIDS related complex (ARC); and acquired immunodeficiency syndrome (AIDS); and including substance abuse treatment records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any; and psychological and social services records, including communications made by me to a social worker or psychologist (if any) may be used and disclosed. I have been offered an opportunity to review the Notice before signing this form. I understand that the terms of the Notice may change and that I may obtain a revised copy by accessing the Midwest Pain & Spine website at www.midwestpain.com or by contacting the Privacy Officer listed in the notice.

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians are not required to agree to this restriction, but if they agree, they will be bound by the agreement. By signing this form, I acknowledge that I have been offered and/or received the Midwest Pain & Spine Notice of Privacy Practices. I have read the consent form or it has been read to me and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

VALUABLES

I understand that Midwest Pain & Spine is not responsible for valuables or personal articles.

CANCELLATION POLICY

Unless cancelled at least 24 hours in advance, a fee will be assessed which is not covered by any insurance carrier. Late cancellation or NO SHOW fee for office consultations or procedures is $50.00. Third and/successive appoints cancelled without acceptable notice will be charged double the rates listed above. Please help us serve you and our other patient by keeping your scheduled appointments.

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Print Patient Name

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Signature of Patient or Responsible Party   Date of Signature