I. Authorization for Treatment

I, patient/patient's legal representative, agree to permit performance of such evaluation, diagnostic and therapeutic procedures that the Pinnacle Pain & Spine (hereinafter referred to as PPS) provider deems necessary for my treatment and care.

II. Authorization for Prescription History

I, patient/patient's legal representative, authorize PPS to view my prescription history to help ensure proper medical treatment.

III. Assignment of Benefits

I assign the benefits payable for services rendered to PPS. I direct my insurers to pay such benefits directly to PPS. In addition, I agree to pay any and all amounts in full that exceed or that are not covered by my insurance coverage which includes any co-pays, deductibles and/or co-insurances. I waive any and all notices and demands in the event of non-payment.

I am aware that I am choosing to utilize a health care provider that may not be in network with my insurance plan. Therefore, I accept responsibility and agree to pay the out-of-network penalty determined by my insurance company.

IV. Authorization for Cellular Consent of Messages/Texts

I expressly consent to the use of my cellular phone number by PPS, our affiliates, or any third party acting on our behalf including collection agencies for calls or text messages, for the purpose of account collection or other related business. Further, I expressly consent to receiving phone calls made by an auto dialer and/or any automatic telephone dialing system from PPS, our affiliates or any third party acting on our behalf, including collection agencies, telephone calls for the purpose of account collection or other related business to any cell phone number obtained by any means from me or another source.

V. Authorization to Release Information

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV, sexually transmitted disease, psychiatric disorders, or drug/alcohol use. I, patient/patient's legal representative, hereby give my consent for PPS to release medical and other relevant information that may be necessary for the completion of claims for reimbursement to the appropriate healthcare insurer, agency or any third party which may be liable for all or part of the charges generated for services rendered.

***Includes but is not limited to: the authorization of payment directly to PPS or benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized person to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee and understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

VI. Medicare/TRICARE/Champus/NOPP

If applying for payment under Title XVII of the Social Security Act (Medicare), I authorize to release medical information about me to the Social Security Administration or its intermediaries or carriers for my Medicare claims (including TRICARE/Champus/Humana Military Claims). I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to PPS.

VII. CERTIFICATION

I certify that to the best of my knowledge and belief, the information provided is complete and accurate. This assignment and consent is valid from the date of signature. I understand that this consent is subject to revocation by me at any time except if the person or entity authorized to make a disclosure had already acted in reliance on this form. Otherwise, subject to applicable law, this consent will expire at the same time that the Provider(s) record retention period for this document expires. This notice must be received prior to release of information.

I am the patient or representative authorized to sign this document. I have read the above and understand its terms.

____

Printed Patient Name

____ ____________________

Signature of Patient/Legal Representative – Relationship Date