CAROLINAS PAIN INSTITUTE, PA
145 Kimel Park Drive • Suite 330
Winston-Salem, NC 27103
(336) 765-6181 • Fax (336) 765-8492

HEALTH CARE CONSENT & AUTHORIZATION FORM

FINANCIAL RESPONSIBILITY: I do hereby expressly agree to pay and guarantee payment in full of any charges for services rendered or to be rendered to the above-named ("Patient") by Carolinas Pain Institute, PA (CPI) and by licensed healthcare providers or their professional entities who may provide services during this patient visit or stay (a "Provider"). Payment is due in full within 30 days of services. In the event of nonpayment, the undersigned guarantees payment of late charges not to exceed 1.5% per month for bills 30 days past due and all costs of collections, including reasonable attorney's fees. In addition, I authorize the transfer of monies paid to CPI by or on behalf of the Patient and otherwise refundable to the Patient or Guarantor, to other accounts at CPI for which the Patient or Guarantor is responsible.

SIGNATURE: ______________________________ WITNESS: ______________________________

ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment of medical benefits payable to me directly to CPI. The rates will not exceed regular charges for similar services. I understand that BILLING OF INSURANCE IS A SERVICE ONLY AND NOT A GUARANTEE OF PAYMENT. If my insurance requires pre-certification for services, I realize it may be my responsibility to get the necessary approvals. I understand that I am personally responsible to CPI for charges not covered by insurance, including charges for health care services determined to be non-medically necessary by a private insurer's utilization review program. I understand that I may choose to continue services that are not covered by the Patient's insurance carrier at my own expense so long as CPI has notified me in advance that the insurance carrier may not cover or continue to cover all services.

MEDICARE – MEDICAID CERTIFICATION: The information given by me in applying for payment under Titles V, XVIII, and/or XIX of the Social Security Act is correct. I request that payment of benefits under Title XVIII (Medicare) and XIX (Medicaid) of the Social Security Act for any services furnished by CPI be made on my behalf. I authorize any holder of medical or other information about me to release to Medicare, Medicaid and their respective agents any information needed for this or a related claim.

PERSONAL VALUABLES: CPI is not responsible for the personal property or valuables of patients. I release CPI of all responsibility for personal property and for valuables.

AUTHORIZATION FOR CARE AND/OR TREATMENT: I hereby consent to outpatient treatment and give permission to CPI to provide the services deemed necessary or advisable in the diagnosis and treatment of this patient. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatment or examination in CPI. I understand that the patient has the right to withhold consent to a medical service that is deemed necessary or advisable by the provider. I understand that physicians in training (residents) and student in health related training programs may participate in the care for the patient or observe special procedures.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I understand that I may revoke or amend the following authorizations at any time except to the extent that action has already been taken:

RELEASE FOR PAYMENT PURPOSES: I authorize CPI to furnish any information relating to this hospitalization or treatment to representatives of any party financially responsible for the Patient's care or to any governmental or charitable agencies. I understand that only that information that is necessary for payment purposes will be disclosed.

RELEASE FOR TREATMENT/QUALITY REVIEW PURPOSES: I authorize release of medical information about the patient to the referring physician, any health care facility or physician to whom the patient may be referred and any extended care facility considered for placement. I understand that a separate consent form is necessary for disclosure of information regarding treatment of alcohol or substance abuse. **I specifically consent to the disclosure of information related to AIDS, HIV infection or other communicable diseases.**

MY SIGNATURE BELOW INDICATES APPROVAL OF THE ABOVE UNLESS OTHERWISE MARKED AND INITIALED.

______________________________ (SEAL) DATE: __________ WITNESS: ______________________________

(If patient is unable to consent or is a minor, complete the following)

Patient is Unable to consent because ______________________________ A minor

And I confirm that I am authorized to consent in the patient's behalf:

______________________________ (SEAL) DATE: __________ WITNESS: ______________________________

Responsible Party