



PATIENT NAME: \_\_\_\_\_  
ACCOUNT NUMBER \_\_\_\_\_

DATE: \_\_\_\_\_  
REFERRING PHYSICIAN: \_\_\_\_\_

**AUTHORIZATION AND GENERAL CONSENT**

I hereby authorize the above named physician or any physician designated by him/her, providing care to the above named patient to render such care including diagnostic procedures and medical treatment as they may deem to be necessary or advisable in the diagnosis or treatment of this patient and I direct this medical imaging center, its agents and employees to follow his/her or their instructions and direction. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to results of treatments, tests or examination in the medical imaging center.

**GUARANTEE OF PAYMENT:**

In consideration for the services to be provided to the patient, the undersigned promise(s) to pay Select Pain & Treatment Centers, and any physician providing services during the period of this examination, all amounts legally due and not paid by Medicare, a third party payor, or other source on my behalf for services so rendered, which payment shall be due in full at the time of service. Additionally, I authorize and assign the DIRECT PAYMENT to Select Pain & Treatment Centers, of any sum I owe or hereafter owe to be made by my attorney out of the proceeds of any settlement of my case, and by an insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me based in whole or in part upon charges made for your services. In the event it is necessary to refer this account to a collection agency or an attorney, the undersigned further agrees to pay all reasonable costs of collection, including reasonable attorney fees. If more than one individual executes this agreement their liability shall be joint and several.

**ASSIGNMENT OF BENEFIT, IF APPLICABLE:**

In consideration for the services rendered or to be rendered, I hereby irrevocably assign and transfer to Select Pain & Treatment Centers, and to any physician providing services, all rights, title and interest, to the benefits payable by any and all third party payors that are or may be liable for the services rendered, to the patient. This irrevocable assignment and transfer shall allow Select Pain & Treatment Centers, or those physicians, to pursue any such right of recovery. Even though I have made this assignment, I understand the Select Pain & Treatment Centers, has the right to demand payment in full from me and the liability shall remain joint and several as between myself and all guarantors and third party payors, and I am responsible for payment for any charges not paid for me on my behalf.

**MEDICARE ASSIGNMENT OF BENEFITS, IF APPLICABLE:**

I hereby assign to Select Pain & Treatment Centers, or any physician(s) providing services to me, any Medicare or Medicaid benefits which may be available to pay for those services provided by the medical imaging center or any physician. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is true and correct.

**AUTHORIZATION TO RELEASE INFORMATION, IF APPLICABLE:**

The undersigned hereby authorizes Select Pain & Treatment Centers and any physicians who have provided medical services during this examination to release information to:  
• The ins. company of record • Medical Assistance programs (including their agents, reps or assignees) • The Social Security Admin or its intermediaries • 3<sup>rd</sup> party Payors

**PERSONAL VALUABLES:**

Select Pain & Treatment Centers, does not accept any responsibility for money, articles of wearing apparel, jewelry, dentures, eyeglasses, hearing aids, or any valuables or belongings brought with any patient or patient's associates to the medical imaging center.

\*\*The undersigned certifies that he/she has read & fully understands the above paragraphs; and further certifies that he/she has received a copy thereof, and is the patient or is legally authorized to act as a patient's agent to execute this document and accept its terms. I further recognize & accept that any & all physicians who furnish services to the above named patient during this examination, are independent contractors & are not agents or employees of Select Pain & Treatment Centers. The undersigned further certifies that services provided by these physicians may be billed separately by these physicians.

**HIPAA Acknowledgement of Receipt of Select Pain & Treatment Centers Notice of Privacy Practices**

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations there under, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

By signing this authorization you acknowledge and agree that Select Pain & Treatment Centers ("Practice") or its Business Associates may use or disclose your Protective Health Information (PHI) for the purpose of providing treatment, for purposes relating to the payment of services rendered, and for the Practice's general healthcare operations purposes.

For purposes of this consent, "Protected Health Information" means any information, including my demographic information created or received by the Practice, that relates to your past, present, or future physical or mental health or condition.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Select Pain & Treatment Centers' HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Select Pain & Treatment Centers has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available and can be received by sending a written request with return address to the center where you were seen.

By signing below, you are acknowledging that you have received, reviewed, understand and agree to the Notice of Privacy Practices of Select Pain & Treatment Centers, which describes the Practice's policies and procedures regarding the use and disclosure of any of your Protected Health Information created, received or maintained by the Practice.

Acknowledged and agreed to by:

PATIENT:  
By \_\_\_\_\_  
Print Name \_\_\_\_\_

\_\_\_\_\_  
Date

or, ON BEHALF OF PATIENT

By \_\_\_\_\_  
Print Name \_\_\_\_\_  
As \_\_\_\_\_

\_\_\_\_\_  
Date