Advanced Pain Medicine, PSC

TREATMENT/FINANCIAL RESPONSIBILITY CONSENT

I desire to be treated at Advanced Pain Medicine, PSC. I understand that I may discontinue treatment at any time.

I understand that in order to receive the appropriate treatment, I will undergo a clinical evaluation consisting of, but not limited to, a medical history and evaluation, and may include an x-ray, MRI, physical therapy evaluation, physical capabilities evaluation, and psychological assessment. The purpose of the evaluation is to assist in identifying the cause of my problem and applying the most effective medical treatments possible.

I understand that the services provided by physical therapists and psychologists, x-rays, interpretation of x-rays, and laboratory investigations are separate from physician fees.

1. As a part of medical procedures and tests, I understand that I may be tested for H.I.V. infection and/or hepatitis, or any other blood-borne infectious disease if a doctor orders the test for diagnostic purposes.

2. Guarantee of Payment: I agree to be responsible for charges resulting from services and supplies rendered at its prevailing rates, unless I qualify for a discount. I agree all bills are due in full upon demand. Should I fail to honor this agreement, I agree to pay any collection cost or attorney fees resulting from the collection of my accounts.

No granting of extensions, indulgences, or forebarances to the patient or any responsible party and no delays or lack of diligence on the part of the practice in enforcing any rights shall in any manner release the undersigned from liability. If the undersigned is more than one person, the obligation shall be joint and several.

3. Assignment of Benefits (other than Medicare of Medicaid): I hereby assign all rights and privileges and authorize payment directly to the practice for any claim filed on my behalf or on the behalf of the person for whom I am duly authorized to sign for insurances benefits. I agree this assignment is primary to any assignment given after this date including any cost relative to attorney fees. I also understand that I am financially responsible to the practice for co-pays, deductibles, coinsurance, and charges not covered by this assignment or by my insurance plan or not paid on a timely basis by the insurance company.

4. Assignment of Benefits (Medicare and Medicaid): I request that payment of authorized Medicare and/ or Medicaid benefits be made to the practice on my behalf for any services or supplies furnished by the practice. I authorize any holder of medical or other information about me to release it to the practice for Medicare and/ or Medicaid Services and its agents or to the Kentucky Medicaid Program and its agents, as appropriate, any information needed to determine these benefits for related services. I understand that I am responsible for any coinsurance, unmet deductibles, and services and items not covered by Medicare and /or Medicaid.

5. The assignment of benefits is intended to grant the practice all right that I may have in connection with benefits or other rights, under ERISA, any plan documents applicable to me, or applicable laws or regulations, including Medicare and Medicaid, associated with the services to the same extent, and to the fullest extent that I would be entitled or have the power to exercise such rights on my behalf or on behalf of my covered dependants.

I hereby authorize all professional staff to release any information acquired in the course of the examination and treatment to: (1) referring physician (2) insurance company (3) worker's compensation carrier (4) the Practice attorneys and consultants in accordance with applicable privacy laws.

I have read the foregoing and understand it. Any questions that have arisen or occurred to me have been answered to my satisfaction.

Date: _____ Participant's Signature: _____