NEUROSURGERY AND SPINE
SPECIALISTS

CONSENT FOR TREATMENT

I give permission to the physicians and staff of Neurosurgery and Spine Specialists ("the Practice") to administer or perform medical treatment. I acknowledge that risks, if any, will be explained t me as well as any other medical options. I understand that no guarantee can be made as to the efficacy or outcome of treatment. The Practice may also use my Protected Health Information (PHI) to treat me or disclose my PHI to other health care providers, such as my referring physician or primary doctor, for purposes related to my treatment.

_____ _____
Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient: _____

CONSENT TO RELEASE INFORMATION

I consent that the Practice may release any medical information that has been obtained during my course of treatment to any lab, hospital, physician or insurance company to answer any inquiries per Federal and State regulations. The Practice may use or disclose my PHI internally or disclose my PHI to other health care providers and entities as necessary to operate their business. The Practice may use and disclose my PHI to contact me for appointment remainders and to inform me of potential treatment options or alternatives. The Practice may use and disclose my PHI to advise a friend or family member that is involved in my care or who assists in taking care of me. My PHI may also be used and disclosed when Federal, State, or local law requires. The Practice may share my PHI with third party "Business Associates" that perform activities on their behalf such as billing software maintenance.

_____ _____
Signature of Patient or Legal Representative Date

FINANCIAL CONSENT

I herby authorize direct remittance of payment of insurance benefits including Medicare, if applicable, to the Practice for all covered medical services rendered. I understand and agree this Assignment of Benefits will have continuing effect for as long as I am being treated by the Practice, and will constitute a continuing authorization, maintained on file with the Practice, for all subsequent and continuing treatment, services, and/or supplies provided to me by the Practice. The Practice may use and disclose my PHI in order to directly bill and collect payment for services and items I receive, to obtain payment from me or from third parties that may be responsible for such costs, or to assist other health care providers in their billing and collections. I accept legal responsibility for charges that my insurance company does not cover and I will pay for these at the time of my visit unless prior arrangements have been made. I am also responsible for all legal fees, collection fees, and interest incurred in the event my account becomes delinquent. I understand that the Practice may not be a participating provider with my insurance company. **Should I receive payment directly from the insurance company, I agree to forward the check and "Explantation of Benefits" to the Practice within 10 days of receipt.** If I fail to provide this information, I understand that I will be held legally responsible for payment in full for all services or equipment that has been provided.

_____ _____
Signature of Patient or Legal Representative Date

WRITTEN ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of **Neurosurgery and Spine Specialists** Notice of Privacy Practices that describes how my health information is used and shared. I understand that the Practice has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer at the doctor's office.

_____ _____
Signature of Patient or Legal Representative Date