New England Regional Headache Center
In the end, only kindness matters.

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PATIENT CONSENT FORM

CONSENT FOR TREATMENT

1. I hereby and voluntary consent to such procedures, including diagnostic procedures and medical treatment, as may be deemed necessary by my physician and his/her associates.
2. I acknowledge that no guarantees have been made to me as a result that may be obtained.
3. I understand that I may have the right to question, discuss or refuse any or all tests and/or treatment.
4. This form has been explained to me and I understand its contents.

CONSENT TO RELEASE MEDICAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS

1. I authorize the release of any medical information necessary to process my insurance claim(s).
2. I authorize the release of any medical information to my Primary Care Physician.
3. I authorize and request payment directly to New England Regional Headache Center, Inc., of medical benefits otherwise payable to me. There will not exceed the facility. regular charges.
4. I understand that I am financially responsible to the facility for any deductibles, co-insurances or non covered service.
5. I agree that this authorization will cover all medical services rendered until such authorization is revoked to me.
6. I authorize the use of the contents of my records for educational purposes or for research activities provided that the patient identity is not revealed in conducting the study.
7. I agree that a photocopy of this form may be used in lieu of the original.

_____ _____/____/____

Signed (Patient or representative) **Date**

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Patient's Name (Printed)