PATIENT AGREEMENTS AND AUTHORIZATIONS

_____

Patient Name (Please Print)

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Premier Brain and Spine Institute, Inc and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by me caregivers to address my needs. (____)(Initial)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.

I authorize use and disclosure of my person health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducing the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (____) (Initial)

ASSIGNMENT OF INSURANCE BENEFITS/ PAYMENT GUARANTTEE/ COLLECTION FEE.

I Authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees. (____)(Initial)

PRIVACY POLICY.

I acknowledge having received the Practice's, "Notice of Privacy Practices". My rights including the rights to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Practice has already made disclosures with my prior consent. (_____)(Initial)

I allow the Practice to give information about my medical condition to the following person.

_____ _____

(Name - Please Print) (Relationship)

_____ _____ _____

Patient or Authorized Person Signature Relationship Date