George I Macrinici / Advanced Pain & Spine Management

PATIENT CONSENT – TREATMENT & RELEASE OF INFORMATION

PLEASE PRINT PATIENTS NAME ____

General Consent for Treatment

I consent to and authorize the administration and performance of all tests and treatments by members of the pain management, general medical staff, and personnel affiliated with George Macrinici, MD/Advanced Pain & Spine Management, which in the judgment of my physician(s), may be considered necessary or advisable for the diagnosis and treatment for the condition for which I am presenting myself at this time. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me as a patient.

Disclosure Statement

My care will be managed by my personal pain physician. My physician may also decide to call in consultants who practice in other specialties who may also be involved in my care.

Assignment of Insurance Benefits & Payment Guarantee

I represent that I currently maintain insurance coverage which will reimburse the charges submitted by George Macrinici, MD/Advanced Pain & Spine Management that includes my treating physician for medical or surgical care which is being provided to me. In consideration of those professional physician services, I assign, transfer, and agree to have such physicians reimbursed directly by my insurance company, managed care organization, or health plan through my assignment of such payments George Macrinici, MD/Advanced Pain & Spine Management for all amounts they are entitled to collect from such payers as reimbursement. I assume responsibility and agree to pay all costs, charges, and expenses of every description for services which are given to me by my treating physician. If my medical insurance is not sufficient to satisfy such costs, charges, and expenses in full, I understand that the resulting balance not covered by my assignment of insurance benefits, is my personal responsibility. I agree to pay such established rates for all physician services, procedures, supplies, and medications used for my diagnosis, assessment, treatment, and recovery. If external collection services become necessary to obtain payment from me, I agree to pay all collection agency and attorney fees, as well as court costs associated with such collection efforts. I agree that all attorney and collection agency fees that do not exceed one third of the full account balance I owe, are reasonable, and I therefore agree to pay the same.

Release of Medical / Surgical Information

I authorize George Macrinici, MD/Advanced Pain & Spine Management to release to my (or the patient's) insurance companies, employer insurance groups, health plans, Medicare / Medicaid program, its insurance carrier, intermediaries or agents, any and all medical records or other information concerning my treatment to obtain reimbursement on my (or the patient's) behalf provided by physicians in this pain group. If appropriate, I authorize the Social Security Administration to release information about my (or the patient's) entitlement to Medicare to George Macrinici, MD/Advanced Pain & Spine Management. I also authorize this physicians' group to release and disclose medical records or other information to third parties with which George Macrinici, MD/Advanced Pain & Spine Management have contracted for purposes of reimbursement. I understand I may revoke this consent to release information to third parties at any time, and that the provision of services is not conditioned on my agreement to disclose information to third parties. However, I further acknowledge that if I revoke my consent, and a third party payer denies payment in whole or part to George Macrinici, MD/Advanced Pain & Spine Management, as a result of my refusal to release information, I will be responsible for paying for any all services rendered by this physicians' group and its employees. This authorization is not intended to allow release of records regarding my treatment for services requiring a restricted release under federal or state law.

Acknowledgement

By signing this agreement, I acknowledge that I have read and understand information contained in this consent and release of medical information form, and that I accept its terms. Any parts in this consent form to which I do not agree, have been crossed off and initialed by me. Any exceptions to this form have been entered and initialed by me.

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, hereby give my consent to George Macrinici, MD/Advanced Pain & Spine Management to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record. I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in the notice. I also understand that a copy of any Revised Notice will be provided to me or made available upon request beginning on the revision's effective date. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I have read the Notice of Privacy Practices from the above named practice. In addition, I want the following information to become part of my permanent record. I understand that I can make changes to this document at any time. I also understand that I can request a copy of this document at any time.

I want to authorize leaving messages on my answering machine, voice mail or sending information to my e-mail address:

Home: _____Yes _____ No **Cell:** _____Yes _____ No **E-Mail** ______Yes _____ No **Work:** _____Yes _____ No

E-Mail Address: ____

I authorize the staff of George Macrinici, MD/Advanced Pain & Spine Management to discuss my protected health care information with the following people:

Spouse (name) or Significant Other: Other Family Members	Relationship:	Phone Number:
______________________________________	____________________	________________________
______________________________________	____________________	________________________

Signed: ____ **Date** ___________________________

(Name of Patient or Authorized Agent and/or Guardian if under 18 years of age.)

If you are not the patient signing, please specify your relationship to the patient _________________________________.

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