

CENTER FOR PAIN RECOVERY
PATIENT AUTHORIZATIONS AND AGREEMENTS

Patient's Name _____

Your clear understanding of our Financial Policy is important to us:

- Co-pay, co-insurance and deductible payments are due at the time of service. We accept cash, checks, Visa/MasterCard and Discover.
- Parents/Guardians accompanying minor patients are responsible for full payment at the time of service.

TREATMENT AUTHORIZATION

I authorize the Center for Pain Recovery to examine, diagnose and treat _____ (Name of Patient), giving reasonable and proper medical care by today's standards which may include: Psychologists, and other various procedures and therapeutic services. I authorize and give the Center for Pain Recovery consent to submit specimens (blood, urine, tissue, etc.) to the laboratory(ies) of choice for analyses and study to include diagnosis for submission for payment to the insurance carrier for the named patient.

_____ (Signature of Patient/Parent or Guardian) Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Center for Pain Recovery to release any information necessary to my insurance company(ies), including governmental health care insurer (such as Medicare and Medicaid) or other health care practitioners involved in the care of the named patient. I understand that the progress of my treatment may be discussed with my referring physician. I understand that I am giving this authorization only in the case of a subpoena or for the release of information necessary for the provision of continuity of care, to determine insurance benefits and the payment of any claims, and/or for all health plan procedures related to the evaluation of the quality and cost-efficiency of care.

_____ Date _____

RESPONSIBLE PARTY AGREEMENT/ASSIGNMENT OF BENEFITS

I do hereby acknowledge that I am the guarantor of this account and agree to pay for services rendered, including any supplies or pharmaceuticals that are provided to me in my treatment. I authorize payment of medical benefits to Center for Pain Recovery, P.A. for professional services rendered. If any charges are submitted to my insurance carrier by either the Center for Pain Recovery or by a provider of healthcare services/products/ equipment which are ordered by my physician for the care of the named patient and these services are not covered medical services or are services where benefits are limited and charges above and beyond these limits are incurred, I agree to pay for any balance deemed applicable according to my health insurance rules and regulations. I understand that CPR will only accept payment from identified payors per insurance card & insurance verification process. I hereby agree that I am responsible for the payment of any co-payment, deductible and co-insurance and that I agree to make payment for these amounts at the time of service. If I am not covered by any insurance carrier, I agree to pay for services rendered at the time of service unless other payment arrangements have been made.

_____ Date _____

MEDICARE/ MEDICAID AUTHORIZATION

I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to the Center for Pain Recovery for any services furnished by my physician to the named patient. I understand my signature requests that payment be made directly to the provider of care and that the provider agrees to accept the charge determination of the Medicare/Medicaid carrier as the full charge, and that the insured patient is responsible only for the deductible, co-insurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare/Medicaid carrier. I attest that I am eligible for Medicare and/ or Medicaid coverage.

_____ Date _____

CANCELLED APPOINTMENT/"NO SHOW" POLICY

If it is necessary for you to cancel any appointment, please advise us at least **24 HOURS in advance for office & therapy appointments and 48 hours in advance of a scheduled procedure. If you miss multiple appointments without complying with the requested notice period, the physician reserves the right to terminate you from the practice.** **NEW PATIENTS:** I understand that if I fail to show up for my appointment, without notice, I will have to pay a fee of \$150.00 in order to be re-scheduled unless I show an extenuating circumstance which management must approve.

_____ Date _____

NURSE PRACTITIONER CONSENT

Our facility has Nurse Practitioners on staff to assist in the delivery of pain management care. A nurse practitioner is not a doctor. A Nurse Practitioner is a Registered Nurse who has received advanced education in the provision of health care. A Nurse Practitioner can diagnose, treat, and monitor acute and chronic diseases as well as provide health maintenance care. I have read the above and hereby consent to the services of a Nurse Practitioner for my health care needs and understand that I may refuse to see a Nurse Practitioner and request to see a physician.

_____ Date _____

OWNERSHIP DISCLOSURE

To further my commitment to quality of surgical care for my patients, I have chosen to be an owner in North Cypress Medical Center. My ownership enhances my ability to direct the manner in which your care is delivered at the facility. If this is of concern to you, I will be happy to answer questions. I am on the medical staff at other healthcare facilities and will be happy to discuss your option of choosing an alternative location. – Mark D. Barhorst, MD

_____ Date _____