Patient ID: _____

Pain Specialists of Greater Chicago Receipt of Notice of Privacy Practices & Patient Information Authorization

I, _____, hereby acknowledge receipt of the PSGC, S.C. Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the 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 will be made available.

I authorize the methods of communication of my protected health information as indicated below. I understand that under the HIPAA guidelines my patient information is kept confidential unless I provide written authorization.

The following person(s) may inquire regarding a medical service or billing statement, pick up records and prescriptions, and take messages pertaining to my health information.

1. _____Relationship _____
2. _____Relationship _____

I authorize PSGC to leave a message or send information regarding my personal health history, such as test results, physician messages, insurance or billing information or appointment information. Please initial each line that you authorize:

_____ Telephone message
_____ with a person listed above
_____ Mail to: ☐ Home ☐ Office
_____ Fax to: ☐ Home ☐ Office Fax number: (_____) _____

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Patient's Name Print Name of Legal Guardian (if applicable)

Policy 1

ID_____

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PAIN SPECIALISTS OF GREATER CHICAGO & CONSENT FOR TREATMENT:

I hereby authorize Pain Specialists of Greater Chicago and its employees and agents to release my medical records documenting my examination and treatment, upon valid request. I also authorize Pain Specialists of Greater Chicago staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries.

I hereby assign payment directly to Pain Specialists of Greater Chicago for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I agree to be financially responsible to Pain Specialists of Greater Chicago, for all charges in the event that I have no insurance or my insurance is rejected, and for any balance or fee not covered by my insurance and/or determined to be my responsibility.

I understand and acknowledge that if Pain Specialists of Greater Chicago files my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim within 30 days.

I hereby request and authorize all doctors, nurses, technicians or affiliated medical personnel, hospitals and health care facilities to furnish all records and reports, including x-rays, photostatic copies, and abstracts or excerpts of all records, and any other information requested relating to any hospitalizations, examinations, treatments, tests or opinions concerning any condition for which I am presently being treated, including psychiatric or substance abuse information. A copy of this authorization shall be as valid as the original of this document.

GENERAL CONSENT TO TREATMENT

By signing below, I (or my authorized representative on my behalf) authorize Pain Specialists of Greater Chicago, physicians. practitioners and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care

RIGHT TO REFUSE TREATMENT

I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options.

PRINT PATIENT NAME:_____

PATIENT (GUARANTOR) SIGNATURE:_____DATE:_____