ID_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS FOR 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, for submitting claims and upon valid request to Insurance companies.

I hereby assign benefits for payments to be made directly to Pain Specialists of Greater Chicago by Insurance companies 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 I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.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 by Insurance companies 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:**_____

PAIN SPECIALISTS OF GREATER CHICAGO

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