

Alpha Pain & Wellness Center

Patient Agreements and Authorizations

CONSENT FOR TREATMENT- I hereby consent to the treatment provided by Alpha Pain & Wellness Center Physicians or other designated health care providers. I understand that Physicians and other health care providers in training may, under the supervision of appropriate personnel, participate in my treatment and I consent to such student involvement in my care.

- There is a possibility that I may be pregnant at this time.
- Yes, I am definitely pregnant at this time.
- No, I am definitely not pregnant at this time.
- I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION I authorize use and disclosure of my personal health information (PHI) for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the health care operations of Alpha Pain & Wellness Center. I authorize Alpha Pain & Wellness Center to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Alpha Pain & Wellness Center may release objective clinical information related to my diagnoses and treatment which may be requested by my insurance company or its designated agent.

ASSIGNMENT OF BENEFITS - In consideration of services rendered, I hereby assign and authorize direct payment to Alpha Pain & Wellness Center, any insurance, health plan or third party payor benefits otherwise payable to me or on my behalf for hospitalization, emergency room, or outpatient services.

RESPONSIBILITY FOR PAYMENT - I acknowledge that I am responsible to pay for all co payments, coinsurances and all services not covered or denied by my insurance plan.

Payment of co pays, deductibles and non-covered services is expected at the time of service. Alpha Pain & Wellness Center accepts the following in satisfaction of your obligation:

- Cash, check or most credit cards. **YOU WILL BE CHARGED \$25.00 WHEN CHECKS ARE RETURNED FOR NON SUFFICIENT FUNDS (NSF).**

LATE CANCELLATION/ NO SHOW - Failure to keep a scheduled massage appointment without a 24 hour notice will result in a **\$25.00 charge**.



Patient's Name

Date of Birth

Patient or Authorized Signature

Date

Relationship to Patient

Witness