Valley Pain Clinic

Health Information Consent And

Acknowledgement of Notice of Privacy Practice

Consent to medical treatment:

I hereby consent to the rendering of medical care which may include diagnostic procedures, medical treatment, and possible hospital admission as considered necessary by **Physicians of Valley Pain Clinic** and member of their office staff.

Release of Health Information:

I authorize that my health information may be released to requesting insurance companies and/or other physicians, or medical facilities. This includes medical history, mental and physical condition, diagnosis, prognoses treatment, and reviewing necessary x-ray, lab results, etc….

I understand that Valley Pain Clinic uses and discloses patient health information to provide treatment, to obtain payment, for health care operations, and administrative purposes. By signing below, I consent to such use and disclosure of the patient's health information. I also consent to the use of disclosure of the patient's health information from which all identifying information has been removed.

I understand that before signing this consent, I have the right to review Valley Pain Clinic' Notice of information practices for more information about how my protected health information may be used and disclosed. I understand that Valley Pain Clinic may change its information practices, but before doing so, a new notice will be posted in the waiting area and each examination room. I may also call Valley Pain Clinic phone number (256) 301-9994 at any time to request a copy of the notice of information practices.

I understand that I have the right to request a restriction on certain uses and disclosures of my health information. Valley Pain Clinic is not required to agree to such restrictions, but if Valley Pain Clinic does agree, it must abide by those restrictions. I understand that I have the right to revoke this consent, in writing, except where Valley Pain Clinic has already made disclosures in reliance on my prior consent.

I understand that Valley Pain Clinic will grant me secure electronic access to my medical records and I have the right to discontinue the option via a written notice at any time.

Payment:

Payment is required at the time of the service. We will provide all the information needed to file your insurance. We will file your Medicare and any supplementary insurance after we hear from Medicare.

Insurance Payment:

I request that payment of insurance benefits be made on my behalf to Physicians of **Valley Pain Clinic** unless payment is made at the time of service. I understand that regardless of the assignment of benefits or what type of insurance coverage I have, I am responsible for any and all charges incurred by myself or my dependents. I also agree to pay **Valley Pain Clinic** the part of the fee which is not covered by my insurance plan.

I instruct my doctor to complain on my behalf to the insurance commissioner, if he deems it necessary.

I have received and read a copy of the notice of privacy practice of Valley Pain Clinic.

Name of Patient or legal representative: ____

Date of Birth: ______________________ SSN: ____________________________

Signature: _________________________ Date: ____________________________