Office locations in San Antonio and Houston, Texas

CONSENT FOR SERVICES

Patient printed name: _____

DOB: _____

CONSENT FOR TREATMENT: I voluntarily consent to evaluation, treatment, diagnostic testing, medication, nursing care and/or therapy which my physician or his designees, determines to be necessary. By signing this consent, I also acknowledge that I may be sent by my physician or his designees to a facility in which the providers of the clinic have an ownership interest. I also acknowledge and agree that in rendering care for me, my physician and his designees may choose to use products in which they may (or may not) have an ownership interest by SASpine and/or contracted physicians, which may include but not limited to, PPI, BHT or Oracle. Although SASpine has preferred vendors, a patient always has the right to choose a different entity for care. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of examination or treatment in the facility.

Additionally, I understand that SASpine is an in-network facility, however, some of SASpine's contracted providers may be considered out of network with insurance carriers such as UHC, Aetna, etc, and have this right as independent contractors. Consequently, patients may be balance billed for some services. Moreover, some of the facilities that SASpine prefers to use may be out of network facilities. That said, I understand that the patient always has a choice in their healthcare and ultimately where they go to receive that care.

USE OF MEDICAL RECORDS IN RESEARCH: I authorize the use of my medical records for external medical or scientific research. By collecting information from medical records, researchers learn about new or better ways to diagnose and treat illnesses. Research results do not identify individuals by name or any other personally identifying characteristics. This authorization does not expire but may be revoked or limited in writing by me at any time. You may disagree with the use of my medical record for this purpose by crossing through this paragraph and initialing in the left margin.

CONSENT FOR PHOTOS: I consent to the taking of photographs for medical record documentation and to still or motion pictures or videos of patient care for educational purposes providing my identity is not disclosed.

CONSENT FOR RELEASE OF INFORMATION: I consent to the release of information about my medical condition to myself and to any healthcare provider or office personnel involved with my current treatment. I understand that I may be contacted by an office representative who is conducting a quality of care review or study, and that information from my medical record has been made available to that representative.

INSURANCE CONSENT: I request that payment of authorized benefits be made to SASpine and to any affiliated providers for any services furnished to me. I authorize this office to release to health plans, and other accident or health insurers, medical or financial information as needed for claims processing, fraud investigation, or quality of care review and studies. I understand that I may revoke this consent for release of information at any time by notifying the office in writing, but such revocation will not apply to information already released.

PRECERTIFICATION/PRIOR AUTHORIZATION AGREEMENT: I understand that I am responsible to comply with the rules and regulations of my insurance company regarding precertification and prior authorization requirements.

GUARANTEE OF ACCOUNT: I agree to pay SASpine for all charges for services not covered by any third-party payer.

_____

Patient signature / legal guardian, legal relationship Date

NOTE: This authorization must be signed by the patient, unless the patient is a minor child or is mentally or physically unable to sign.

Reason patient unable to sign:

_____

Signature: _____

Date: _____