CAROLINA PAIN CENTER

Relieving Pain
Restoring Function

AUTHORIZATION AND AGREEMENT OF MEDICAL TREATMENT, INSURANCE BENEFITS AND FINANCIAL RESPONSIBILITY

The undersigned hereby makes the following Acknowledgements and Agreements regarding medical treatment, insurance benefits, financial responsibility and release of information to be provided by Carolina Pain Center, P.C. or associates or assistants to the patient whose name appears below.

CONSENT FOR EXAMINATION: I understand that medical treatment may be necessary for the patient by Carolina Pain Center, P.C. or associates or assistants. I understand the examination procedures will be explained to me and I shall consent to the rapid, partial or complete medical examination of the parts of the body I show to the examiner. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examinations to check abnormalities found and treated, lies with me and not with the physician. I hereby release my examiner from all responsibility in connection with this examination.

CONSENT FOR TREATMENT: I understand that medical treatment is necessary for the patient by Carolina Pain Center, P.C. or associates or assistants. I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the physician. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments.

INSURANCE BENEFITS: As a courtesy to patients of Carolina Pain Center, P.C. acceptable insurance claims will be processed. I hereby authorize my insurance benefits to be paid directly to Carolina Pain Center, P.C. I am financially responsible for all office visit charges, which are payable at time of service, all deductibles, coinsurance (copay), and non-covered and/or disallowed services by Insurance Carriers, i.e. Medicare, Blue Cross Blue Shield, Medicaid, Private Insurance or Worker's Compensation. If it becomes necessary to refer this account to a collection agency, I agree to pay collection costs, court costs and reasonable attorney fees.

NO INSURANCE BENEFITS: For patients with NO insurance, I acknowledge I am financially responsible for all charges for services and payment is expected at time of service unless arrangements are made in advance for a payment plan. Patients are encouraged to discuss fees with the finance department of the practice prior to any major medical or surgical procedure.

RELEASE OF INFORMATION: I hereby authorize Carolina Pain Center, P.C. to release any information in the course of my examination or treatment as may be needed to process my insurance claims and to inform my private physician as to my course of treatment.

I have read the above Acknowledgments and Agreements and fully understand the same.

_____
Patient's Name (please print)

_____ _____
Signature of Patient or Guardian Date

_____ _____
Relationship to Patient Witness

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