Payment Authorization/Consent for Treatment/ Privacy Policy (HIPAA)

AUTHORIZATION

I, the undersigned certify that I (or my dependent) have insurance coverage and assign payments directly to Physician Pain Management. I understand that I am financially responsible for all charges not covered by my insurance plan, including co-pays, deductibles, non-covered services, and any other outstanding charges. I hereby authorize Physician Pain Management to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

X Signature_____Date_____

Are you the policy holder? Yes__ No __ If not please see receptionist.

CONSENT FOR TREATMENT

Having voluntarily presented myself (or my dependent) to Physician Pain Management, I acknowledge recognition of the fact that the evaluation and treatment received, advised, or deemed necessary, to be the judgment of Dr. Rubin.

X Signature_____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (HIPAA)

☐ I have read a copy of the Physician Pain Management Privacy Notice

☐ Physician Pain Management has offered me a copy of the Privacy Notice which I have declined and has given me the chance to discuss my concerns and questions about the privacy of my health information.

X Signature_____Date_____

ADDITIONAL PERSON(S) AUTHORIZED TO MAKE THE USE OR DISCLOSURE OF MY PHYSICIAN

Physician Pain Management values your privacy. Your medical information will not be given to anyone without your written consent. If you want anyone other than your referring physician to have access to your medical information, please list their name, address, relation, and phone number below. (Note: Uses and disclosures may be permitted without prior consent in an emergency.)

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

X Signature_____Date_____

☐ **This will never expire**

The staff of PPM should complete this section if Acknowledgement Form is not signed by the Patient:

1. Does the patient have a copy of the Privacy Notice? **Yes__ No __**
2. Please explain why the patient was unable to sign an acknowledgement form and our efforts in trying to obtain the patient signature: _____

Employee Signature: _____ Date _____