LEGACY PAIN ASSOCIATES
PATIENT AUTHORIZATIONS AND AGREEMENTS

Patient's Name _____

Your clear understanding of our Financial Policy is important to us:

- Co-pay, co-insurance and deductible payments are due at the time of service. We accept credit cards and checks.
- Parents/Guardians accompanying minor patients are responsible for full payment at the time of service.

TREATMENT AUTHORIZATION

✓ I authorize the Legacy Pain Associates to examine, diagnose and treat the above-named patient, giving reasonable and proper medical care by today's standards which may include: Psychologists, and other various procedures and therapeutic services. I authorize and give the Legacy Pain Associates consent to submit specimens (blood, urine, tissue, etc.) to the laboratory(ies) of choice for analyses and study to include diagnosis for submission for payment to the insurance carrier for the named patient.

_____ (Signature of Patient/Parent or Guardian) Date_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Legacy Pain Associates to release any information necessary to my insurance company(ies), including governmental health care insurer (such as Medicare and Medicaid) or other health care practitioners involved in the care of the named patient. I understand that the progress of my treatment may be discussed with my referring physician. I understand that I am giving this authorization only in the case of a subpoena or for the release of information necessary for the provision of continuity of care, to determine insurance benefits and the payment of any claims, and/or for all health plan procedures related to the evaluation of the quality and cost-efficiency of care.

_____ (Signature of Patient/Parent or Guardian) Date_____

RESPONSIBLE PARTY AGREEMENT/ASSIGNMENT OF BENEFITS

I do hereby acknowledge that I am the guarantor of this account and agree to pay for services rendered, including any supplies or pharmaceuticals that are provided to me in my treatment. I authorize payment of medical benefits to Legacy Pain Associates for professional services rendered. If any charges are submitted to my insurance carrier by either the Legacy Pain Associates or by a provider of healthcare services/products/ equipment which are ordered by my physician for the care of the named patient and these services are not covered medical services or are services where benefits are limited and charges above and beyond these limits are incurred, I agree to pay for any balance deemed applicable according to my health insurance rules and regulations. I understand that LPA will only accept payment from identified payors per insurance card & insurance verification process. I hereby agree that I am responsible for the payment of any co-payment, deductible and co-insurance and that I agree to make payment for these amounts at the time of service. If I am not covered by any insurance carrier, I agree to pay for services rendered at the time of service unless other payment arrangements have been made.

_____ (Signature of Patient/Parent or Guardian) Date_____

MEDICARE/ MEDICAID AUTHORIZATION

I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to the Legacy Pain Associates for any services furnished by my physician to the named patient. I understand my signature requests that payment be made directly to the provider of care and that the provider agrees to accept the charge determination of the Medicare/Medicaid carrier as the full charge, and that the insured patient is responsible only for the deductible, co-insurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare/Medicaid carrier. I attest that I am eligible for Medicare and/ or Medicaid coverage.

_____ (Signature of Patient/Parent or Guardian) Date_____

CANCELLED APPOINTMENT/"NO SHOW" POLICY

If it is necessary for you to cancel any appointment, please advise us at least **24 HOURS in advance for office appointments and 48 hours in advance of a scheduled procedure. If you miss multiple appointments without complying with the requested notice period, the physician reserves the right to charge a fee as posted in the office up to the right to terminate you from the practice**. **There will be a fee of $50 for No Show appointments and a fee of $150 for No Show for procedures. NEW PATIENTS**: I understand that if I fail to show up for my appointment, without notice, I will have to pay a fee of $150.00 in order to be re-scheduled unless I show an extenuating circumstance which management must approve.

_____ (Signature of Patient/Parent or Guardian) Date_____

LEGACY PAIN ASSOCIATES
Privacy Policy Acknowledgement

I have reviewed The Legacy Pain Associates's ***Notice of Privacy Practices*** prior to signing this document. This Notice of Privacy Practices has been provided to me and is available at the front desk of The Legacy Pain Associates's lobby. I understand I am entitled to receive a copy of this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of health care operations of The Legacy Pain Associates. It also describes my rights and The Legacy Pain Associates's duties with respect to my protected health information.

My "protected health information" encompasses health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health and identifies me or provides reasonable basis for identifying me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the practice's healthcare operations. The Legacy Pain Associates is not required to agree to the restrictions that I may request. However, if The Legacy Pain Associates agrees to a requested restriction, that restriction is binding on both the practice and the attending physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that The Legacy Pain Associates has taken action in reliance on this consent.

The Legacy Pain Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.

I consent to the use or disclosure of my **protected health information** by **The Legacy Pain Associates** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the practice's health care operations.

_____ _____

Signature of Patient or Personal Representative ***Date***

_____ _____

Printed Name of Patient or Personal Representative ***Signature of Parent if Patient is a Minor***

_____ _____

Description of Personal Representative's Authority ***Printed Name of Parent if Patient is a Minor***

Documentation of Good Faith Efforts

Patient Name _____ *Date* _____

The patient presented for his/her appointment or procedure on this date and was provided with a copy of The Legacy Pain Associates's Privacy Notice. A good faith effort was made to obtain a written acknowledgment of receipt of the Notice. However, an acknowledgment was not obtained because:

- ❑ Patient refused to sign.
- ❑ Patient was unable to sign or initial because:

  _____
- ❑ There was a medical emergency (The Center will attempt to obtain acknowledgment at the next available opportunity).
- ❑ Other reason, described below:

  _____

Signature of employee completing form: _____