

# BOSTON PAINCARE CENTER

## a. Consent To Treatment

1. I voluntarily give my informed consent to be treated at Boston PainCare Center(henceforth referred to as BPC). I understand that the provision of health care services may involve significant risk. I understand that the physicians and employees of BPC will fully inform me of the risks, benefits and alternatives to specific recommended treatments so that I may give my informed consent to a specific medical procedure or treatment. I understand that I have the right to refuse any diagnostic or therapeutic treatment procedure.
2. I acknowledge that no guarantees have been made to me concerning the results or outcomes of diagnostic tests, evaluations, treatments or procedures.

## b. Consent for Use and Disclosure of Information for Payment, Treatment and Healthcare Operations

1. I consent to BPC's release of my medical information so that BPC may treat me, seek payment from third parties for such treatment and generally carry on BPC's health operations (i.e., quality assurance). I also consent to BPC's release of my medical information to insurers and providers outside of BPC when necessary so that these providers may treat me, seek payment for that treatment, and carry on their health care operations. Without limiting the foregoing, my medical information may be released to the following parties:
  - a. My primary care physician or any other physicians caring for me;
  - b. My workman's compensation carrier, if my treatment is related to an accident suffered at work;
  - c. Third-party payers (insurers);
  - d. Billing services;
  - e. Other entities as required by law.

Any exclusions to the release of my medical record information are listed below:

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## c. Patient Responsibilities

I hereby irrevocably assign and transfer to BPC the benefits to any and all insurance policies covering myself for medical services provided to me by BPC. BPC will bill my insurance on my behalf. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to BPC any plan documents, insurance policy and/or settlement information upon written request from BPC in order to claim such medical benefits, reimbursement or any applicable remedies. BPC will attempt to verify benefits for the patient, however verification is not a guarantee of benefits and ultimately coverage and payment lies at the sole discretion of the third-party payer. I understand that I am financially responsible for the charges associated with the provision of care at BPC. It is my responsibility to pay all copayments at the time services are rendered, and to notify BPC when a change in or loss of insurance coverage occurs. BPC may not be a plan provider for your insurance company, and this may result in your insurer forwarding you payment for services rendered at BPC. In the event of a benefits check is sent to me for services rendered at BPC, I agree to endorse the check immediately and forward to BPC by certified mail, or pay by personal check (with a copy of the explanation of benefits from my insurance carrier) within 48 hours for the value of the benefits check. I understand that failure to reimburse BPC for insurance benefits received for medical services rendered will cause the full open balance of all charges to become due and payable immediately, and that I will be responsible for legal and collection fees if incurred. I hereby authorize BPC to appeal claims under the Employee Retirement Income Security Act (ERISA) and/or state laws when applicable as situations occur. A photo copy of this document is to be considered as valid as the original. I have read and do fully understand this agreement.

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Patient / Legal Guardian Signature

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Date

**d. Consent to Obtain and Release Protected Health Information**

1. I understand that my medical records currently contain or will in the future contain sensitive information. Unless otherwise indicated below, I consent to the release of such information as part of my medical record to insurers, billing service agents and other providers for the purpose of obtaining treatment for me, payment for the treatment provided to me, and so that these entities can carry on their health care operations.
2. I understand that BPC may require details regarding your health history in order to provide care to you. I specifically consent to the release of such information as listed below from the following facilities.

PCP Name: \_\_\_\_\_ Specialist Name: \_\_\_\_\_

Specialist Name: \_\_\_\_\_ Facility Name: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

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3. The following information will be requested from your health care providers unless specifically prohibited below:

- History and physical exam;
- Progress notes;
- Lab reports including HIV/AIDS status;
- Information regarding treatment for substance abuse (alcohol or Drug);
- X-Ray reports
- Information related to mental health including psychotherapy notes, social history and assessment;
- Information related to confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor, or other allied health or human services professional

4. I understand that this authorization will be in effect for a period of two years from the date of the signing of this document. I understand that I may revoke this authorization at any time by notifying BPC in writing, and it will be effective on the date noted except to the extent that action has already been taken in reliance upon this authorization. I understand that information disclosed is confidential, and is obtained from and/or provided to only to the above named entities. I further understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

I agree to allow BPC to obtain and release the above information

I do not agree to allow BPC to obtain or release the above information

I agree to allow only the following information to be obtained and released by BPC:

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\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Guardian Signature

\_\_\_\_\_  
Date