NAME:
DOB:
PATIENT ACCOUNT #:

INSTITUTE FOR LOW BACK AND NECK CARE
AUTHORIZATION AND CONSENT FORM

General Release of Information & Assignment of Benefits:
I authorize the Institute for Low Back and Neck Care, on behalf of myself and/or my dependents, to furnish medical records, including films and other information related to health care services provided by the Institute for Low Back and Neck Care, to Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, in which my providers participate, and the contractors and third party administrators of any of these parties as may be necessary for the payment of a bill, determination of benefits, utilization and quality review purposes, or health care operations. I hereby assign all authorized medical and surgical benefits to which I am entitled and I request payment of all such authorized benefits be made on my behalf to the Institute for Low Back and Neck care for any services furnished by the Institute for Low Back and Neck Care.

Release of Information by Payers and Networks:
I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, and their contractors and third party administrators to share my health records and information obtained from the Institute for Low Back and Neck Care or any other provider, with the Institute for Low Back and Neck Care, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which my provider participates, and the contractors and third party administrators of these parties as needed for payment and health care operations.

Payment Agreement:
I understand that I am financially responsible and agree to pay for any charges for the care and treatment rendered to me not covered by my insurance plan or if I do not have active insurance coverage.

Release/Retrieval of Information to/from Health Care Facilities, Pharmacy Benefit Payers and Providers:
I authorize the release or retrieval of my medical treatment information, including films, prescription medication history and other information related to such services for health care operations to or from third party pharmacy benefit payers, other health care facilities, and other providers who may be involved in my medical treatment.

Patient Information:
_________By initialing, I acknowledge that I have received the Notice of Privacy Practices from the Institute for Low Back and Neck Care.

I understand all of the above and I have had the chance to ask questions and all of my questions have been answered to my satisfaction. This consent does not expire until I revoke it and I understand that I must do so in writing. I understand that I have the right to revoke my consent at any time and that my revocation shall have no effect on any actions taken prior to my revocation.

____
Patient's Name

______________________________________ ______________________
Signature of Patient or Personal Representative Date

____
Relationship to Patient (if patient unable to sign)