Patient Consent Form

Consent for Treatment

I voluntarily consent to the rendering of care, including treatment and the performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician, and it is the responsibility of the staff to carry out the instructions of such physician(s).

Release of Information

By signing this form, I am allowing Lexington Spinal Care to use and disclose my protected health information for the purpose of treatment, payment and health care operations. Their "Notice of Privacy Practices" provides more detailed information about how they may use and disclose this private information. I have a legal right to review the "Notice of Privacy Practices" before I sign this consent, and I am encouraged to read it in full.

The "Notice of Privacy Practices" is subject to change. If it is changed, the patient may obtain a copy of the revisions by telephoning the office at (803) 356-1350. I have a right to request that this office restrict how they use and disclose my protected health information for the purpose of treatment , collection of payment, or health care administrative operations. This office is NOT required by law to grant said request. However, if they do agree to honor my written request, they are bound by that agreement.

I have the right to revoke this consent in writing, except to the extent that this office may have already used or disclosed my protected health information in reliance on my consent.

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

I authorize payment of any medical benefits from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and service rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged products or professional services rendered will be immediately due and payable.

Medicare/Medicaid Consent to Release Information:

I certify that the information given by me in applying for payment under TITLE XVIII and/or TITLE XI of the social security act is correct. I authorize any holder of medical or other information about me, to release to the SSA or their intermediary any information needed for this or any related Medicare or Medicaid claims.

_____ _____

Patient Signature **Date**

_____(Witness Initials)