ROCKY MOUNTAIN
BRAIN & SPINE
INSTITUTE

Patient Name: (Last, First): _____
Date of Birth: ____/____/_____

Consent of Medical Treatment

1) **CONSENT FOR HEALTH CARE SERVICES**. I authorize physician(s), physician assistants(s), and/ or designees to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Rocky Mountain Brain & Spine Institute practices. This authorization includes, but is not limited to: medical services, diagnostic procedures, diagnostic imaging, intravenous therapy, medications, injections, laboratory services, and other services or procedures, which my physician or provider considers necessary. My health care provider(s) will discuss with me the risks, benefits and alternatives to recommended treatments. I understand that health care services may be rendered by students, interns or residents under supervision. I understand that Rocky Mountain Brain & Spine Institute may release copies of my medical records to other physicians, practitioners and healthcare providers or facilities for treatment and other purposes, as permitted by law. I acknowledge that no promises or guarantees have been made to me regarding treatment of services rendered in/ by the practice. I acknowledge that no promises or guarantees have been made to me regarding outcome from recommendations or treatment by Rocky Mountain Brain & Spine Institute.

2) **NON-ROCKY MOUNTAIN BRAIN & SPINE INSTITUTE PROFESSIONALS/ FACILITIES**. I understand that I may receive services from professionals or facilities who provide care to me or are involved in my care/ treatment who are not employees or agents of Rocky Mountain Brain & Spine Institute. These professionals may include other physicians/providers requested by my physician to participate in my care as well as radiology, pathology, neuromonitoring technicians and neuromonitoring readers, and laboratory services. As a result, I understand that I may receive bills for these services that are separate from the bills I receive from Rocky Mountain Brain & Spine Institute. **I understand that, in some cases, these non- Rocky Mountain Brain & Spine Institute professionals or facilities may not be participating providers or facilities under my insurance plan. I understand it is my responsibility to verify whether professionals/facilities providing my care are participating providers/ facilities under my insurance, and that I may be responsible for any out of network costs incurred due to non-participation.**

3) **MEDICARE AND/OR MEDICAID CERTIFICATION.** I certify that the information given to me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the practice of my behalf for the charges for which the practice is authorized to bill in connection with these health care services.

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4) **FINANCIAL AGREEMENT.** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of the practice and or physicians rendering services not otherwise paid by my health insurance or other payor. Estimated patient responsibility is due at the time of service. Any remaining charges are due and payable upon receipt of the bill. I understand the practice may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that nay refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the practice. **I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to my account by the practice or any entity to which the practice assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account, as well as to the use of technology including auto-dialing and/or prerecorded messages in contacting me.**

5) **PREAUTHORIZATION REQUIREMENTS.** I understand that it is my sole responsibility to verify all pre-authorizations are in place and to comply with all requirements of nay insurance plan upon which I am relying for coverage of the practice's and physicians' charges. I also understand that my insurance may require an office visit referral from my primary care physician to see a specialist. It is my responsibility to contact my primary care physician and acquire the necessary referral prior to my scheduled appointment. If a referral is not obtained prior to my appointment, I may be financially responsible for the charges incurred during the visit.

6) **ASSIGMENT FOR DIRECT PAYMENT.** I authorize and direct hta payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my physicians/ providers. I understand that I am financially responsible to the practice or my physician/ providers for charges not covered or paid pursuant to this authorization.

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7) **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.** I acknowledge that Rocky Mountain Brain & Spine Institute has offered me a copy of its Notice of Privacy Practices. I understand this acknowledgement in no way affects the care I shall receive at the practice.

By checking one of the circles below, I acknowledge:

- o **I have been offered or accepted a copy of the Notice of Privacy Practices**
- o **I declined a copy of the Notice of Privacy Practices**

Practice Representative Comments: _____

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

_____ _____ _____

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON NAME (PRINT) DATE TIME

_____

RELATIONSHIP/ REASON WHY PATIENT IS UNABLE TO SIGN

_____

ADDRESS OF PATIENT