KINSTON REGIONAL PAIN CENTER

PATIENT AUTHORIZATION AND SIGNATURE PAGE
BILLING AUTHORIZATION AND ASSIGNMENT OF BENEFITS

1. I hereby assign to an authorized payment directly to Kinston Regional Pain Center, PLLC, for all benefits payable under the terms of any insurance policy listed. Authorize the release of any medical information necessary to process my insurance claims or to continue my medical care.

2. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its a intermediaries or carriers any information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefitss apply. I also understand that I am responsible for the deductible, Coinsurance and any non-covered services as determined by Medicare.

AUTHORIZATION FOR TREATMENT

I hereby consent to the rendering of medical care, which may include routine diagnostic procedures, laboratory testing, medical and or surgical procedures and physical and or occupational therapy performed by authorized positions and or staff members of Kinston Regional Pain Center, PLLC.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

1. We are committed to protecting your privacy and ensuring that you're protected health information issues and disclose appropriately. The notice of privacy practices identifies ail potential uses and disclosures of your protected health information by our practice and outlines your rights with regard to the use and disclosure of that information.
2. I acknowledge understanding of and have received a copy of the Notice of Privacy Practices for Kinston Regional Pain Center, PLLC.

ACKNOWLEDGEMENT OF RECEIPT OF THE PATIENT FINANCIAL AGREEMENT

1. I acknowledge understanding of and I have received a copy of the patient financial agreement.
2. I Agree to abide by the terms of the patient financial agreement.

_____
Print Patient's Name

X _____
Patient/Parent or Guardian Signature

Date: _____

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