Authorization and Consent for Treatment

Assignment of Benefits and Authorization to Release Medical Information

I understand and agree that payment of authorized benefits under Medicare and/or any of my insurance carriers will be made to me or on my behalf to the provider or supplier of any services furnished to me by that provider or supplier. I authorize any holder of my medical information to release it to AK Pain & Spine Center, the Health Care Financing Administration (HCFA), the listed insurer and/or agents of the company and/or the listed responsible person(s), and any information necessary to determine my benefits or the benefit for the related services. If my insurance plan does not participate in the AK Pain & Spine Center network, or if I am a self-pay patient, assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification

In consideration of services provided to me by AK Pain & Spine Center, I agree to be financially responsible and to pay charges for all services ordered by my provider(s). I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain consistent payments, my account will be referred to a collection agent and/or attorney and I agree to pay all collection related charges.

I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plan's provisions. I understand that my failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

Consent to Treatment

As an AK Pain & Spine Center patient I voluntarily consent to the rendering of such care and treatment as the AK Pain & Spine Center providers and personnel, in their professional judgment, deem necessary for my health and well-being.

My consent shall include medical examination and diagnostic testing, including, but not limited to, minor surgical procedures. My consent shall also include the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my AK Pain & Spine Center provider nor any care center staff has made any guarantee or promise as to the results that may be obtained.

Consent to Call

I understand and agree that AK Pain & Spine Center may contact me using automated calls. emails, and text messaging sent to my landline and mobile device. These communications may notify me of test results, treatment recommendations, outstanding balances, or any other communications from AK Pain & Spine Center.

I understand that I may voluntarily "opt-in" to receive automated text message communications from AK Pain & Spine Center and its partners by informing my provider's staff or visiting my Athena Patient Portal, and agreeing to any additional Terms and Conditions established by my mobile carrier.

I hereby acknowledge that I have received AK Pain & Spine Center's Financial Policy and Notice of Privacy Practices. I agree to the terms of AK Pain & Spine Center's Financial Policy, the sharing of my information via HIE," and consent to my treatment by AK Pain & Spine Center providers.

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Print Name	Signature	Date