PAIN SPECIALISTS OF TEXAS, LP, 4927 LAKE RIDGE PARKWAY, SUITE 170, GRAND PRAIRIE, TX 75052

CONSENT, ASSIGNMENT AND RELEASE:

I AM PRESENTING MYSELF TO PAIN SPECIALISTS OF TEXAS (PSTX) FOR EVALUATION, DIAGNOSIS AND OR TREATMENT OF MY MEDICAL CONDITION. I GIVE MY CONSENT FOR MY PHYSICIAN(S) OR HIS DESIGNEES TO ORDER AND/OR PERFORM ALL EXAMS, TESTS, PROCEDURES, AND ANY OTHER CARE DEEMED NECESSARY OR ADVISABLE FOR THE EVALUATION, DIAGNOSIS AND TREATMENT OF MY MEDICAL CONDITION. THIS CONSENT IS VALID FOR EACH VISIT I MAKE TO PSTX UNLESS REVOKED BY ME IN WRITING.

I UNDERSTAND THAT TEXAS LAW PROVIDES, AND I GIVE CONSENT, THAT I MAY BE TESTED FOR POSSIBLE EXPOSURE TO CERTAIN COMMUNICABLE DISEASES, INCLUDING BUT NOT LIMITED TO THE HUMAN IMMUNODEFICIENCY VIRUS (HIV), THE VIRUS ASSOCIATED WITH AIDS, HEPATITIS B AND C, AND SYPHILIS. SUCH TESTING WILL BE CONDUCTED PURSUANT TO APPLICABLE LAWS AND CAN INCLUDE BUT IS NOT LIMITED TO THE FOLLOWING SITUATIONS: 1) IF A HEALTH CARE WORKER IS EXPOSED TO MY BLOOD OR OTHER BODILY FLUID; 2) IF A MEDICAL OR SURGICAL PROCEDURE IS TO BE PERFORMED WHICH COULD EXPOSE HEALTH CARE WORKERS TO MY BLOOD OR BODILY FLUIDS; 3) TO SCREEN BLOOD, BLOOD PRODUCTS, ORGANS OR TISSUES TO DETERMINE SUITABILITY FOR DONATION; 4) IF I AM PREGNANT.

IF I AM ELIGIBLE FOR HEALTH CARE BENEFITS UNDER ANY FEDERAL OR STATE PROGRAM, INCLUDING BUT NOT LIMITED TO MEDICARE OR MEDICAID, I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER SUCH PROGRAMS, INCLUDING TITLE XVIII AND XIX OF THE SOCIAL SECURITY ACT, IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR INTERMEDIARIES OR CARRIERS INFORMATION NEEDED FOR ANY FEDERAL OR STATE PROGRAM RELATED CLAIMS. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE TO PAIN SPECIALISTS OF TEXAS ON MY BEHALF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL DEDUCTIBLE AND COINSURANCE AMOUNTS UNDER THESE PROGRAMS.

I HEREBY AUTHORIZE ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME TO BE PAID DIRECTLY TO **PAIN SPECIALISTS OF TEXAS**. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT INSURANCE PAYS AND FOR ALL SERVICES RENDERED TO MY DEPENDENTS. IF MY ACCOUNT BECOMES DELINQUENT AND IT IS NECESSARY FOR MY ACCOUNT TO BE REFERRED TO ATTORNEYS OR COLLECTION AGENCIES, I WILL PAY ALL CHARGES THAT ARE MY OBLIGATION, ALONG WITH REASONABLE ATTORNEY'S FEE AND OTHER COLLECTION EXPENSES.

I ALSO AUTHORIZE **PAIN SPECIALISTS OF TEXAS** TO RELEASE INFORMATION TO SECURE PAYMENTS ON MY BEHALF. I AUTHORIZE THE USE OF MY SIGNATURE TO BE USED ON ALL INSURANCE FORMS.

I UNDERSTAND THE **PROTECTED HEALTH INFORMATION (PHI) POLICY** FOR PAIN SPECIALISTS OF TEXAS IS POSTED IN THE WAITING AREA AND ON THE WEBSITE **PAINSPECIALISTSTX.COM**. COPIES ARE ALSO PROVIDED BY THE OFFICE ON REQUEST.

SIGNATURE OF PATIENT____ **DATE**_________________________________

SIGNATURE OF AUTHORIZED PARTY, IF NOT PATIENT____ **DATE**_______________

PAIN SPECIALISTS OF TEXAS INFORMATION RELEASE AUTHORIZATION

It is the office policy of Pain Specialists of Texas not to release confidential and/or unauthorized information without the expressed consent of the patient. When returning telephone calls and the answering machine picks up, we cannot leave a detailed message if your name is not on the recorded message to identify the residence.

I authorize Pain Specialists of Texas to contact me at the following numbers:	Can leave detailed message	
Home Telephone Number ________________________	yes	no
Work Telephone Number _________________________	yes	no
Cell Telephone Number ____________________________	yes	no
Alternative Telephone Number _______________________	yes	no

If you would like other individuals to have access to your health/billing information, please list the names of the people below:

NAME RELATIONSHIP LIMITATIONS ON RELEASING INFORMATION

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