PAIN CONSULTANTS OF SOUTH MISSISSIPPI
PAIN TREATMENT CENTER
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CLINIC POLICY/AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned understand that I am responsible for payment of services rendered to me by this clinic. I understand that this clinic will file my insurance as a courtesy to me, but that I will be fully responsible to see that this clinic gets paid for all services that were rendered. I will be responsible for all deductibles and co-pays. Payment is due at the time of service. I understand that if my account should ever require action by a collection agency or attorney in order to insure payment, the fees charged by these agents may be added to the balance due and unpaid on my account. I authorize Pain Consultants of South Mississippi, Pain Treatment Center to release any and all medical records in their possession to any other physician or facility that you refer the undersigned to for treatment. I authorize this clinic to release any and all medical records to any treating physician or insurance company needed to determine benefits or treatment of patient. I, the undersigned understand that the medial record may include information pertaining to diagnose/treatment of alcohol/drug abuse, psychiatric conditions, HIV/aids and I consent to the release of such information to any other physician or facility requesting medical records.

MEDICARE

I, the undersigned understand that this clinic accepts assignment of Medicare. I agree to be responsible for my deductible and/or any uncovered charges as well as 20% of the allowance of covered services. I request that payment of authorized Medicare benefits be made on my behalf to this nurse practitioner, physician and facility for any services furnished me by the practitioner. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or benefits payable for related services.

MEDICAID

I, the undersigned agree to be responsible for any services not covered by Medicaid, I request that payment of authorized Medicaid benefits be made on my behalf to this nurse practitioner, physician and facility. I authorize any holder of medical and other information about me to release to the division of Medicaid or its fiscal agent any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE____ DATE:__________________________