The Advanced Spine Center
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CONSENT to the USE AND DISCLOSURE OF HEALTH INFORMATION
For the TREATMENT, PAYMENT, HEALTHCARE OPERATIONS & FINANCIAL POLICY

I the undersigned understand that as part of my treatment, Advanced Spinal Care & Associates, LLC originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any future care or treatment. I understand that this information serves as:

- Basis for planning my care and treatment.
- A means of communication among any other health professionals who might contribute to my care, i.e.: via facsimile, telephone, etc.
- A source of information for applying diagnosis and surgical information to my account to process for payment.
- A means by which a third-party payer can verify that services billed and accurate and actual.
- As a tool for routine healthcare operations, such as assessing quality, and reviewing the competence of healthcare officials.
- A means by which an insurance appeal at any stage, may be filed.
- You are responsible to supply our staff with any and all insurance identification card(s) at the time of your appointment. If your insurance carrier requires a referral from your primary doctor, it is you're responsibility to present this to our receptionist prior to your visit, as we cannot bill your insurance company without it. If you do not obtain a referral when your insurance requires one, you will be required to pay for the visit in full at the time of visit. All co-pays are to be collected prior to your visit.
- Any outstanding balance for which a patient is responsible is due within 30 days of billing. Any patient balance that has gone 90 days without a patient payment is subject to immediate collection process. Services that are transferred to a collections status will be subject to a $50.00 service fee per occurrence.
- A returned check fee of $35.00 will be applied to any account for checks returned to us for insufficient funds.
- I assign all benefits for my medical services to Advanced Spinal Care & Associates, LLC.

I understand Advanced Spinal Care & Associates, LLC will take care to ensure that any and all information pertaining to me and my treatment at this facility will be handled with an emphasis on maintaining my privacy at all times. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that this facility is not required to agree to these restrictions in the event of an emergency. I understand that I may revoke this consent in writing at any time, but not to the extent the organization has already acted in.

- I authorize Advanced Spinal Care & Associates, LLC to release my medical records to the following **friend** or **family member**:

  Name: _____Relationship:_____

  Name: _____Relationship:_____

_____
Print Name of Patient or Legal Guardian

_____ _____
Signature Date