TEXAS PAIN CENTERS
3519 TOWN CENTER BLVD, SUITE B
SUGAR LAND, TX 77479
PHONE: 832-730-PAIN (7246)
FAX: 844-302-5696

PATIENT AUTHORIZATIONS AND IRREVOCABLE ASSIGNMENTS

Texas Pain Centers

1. I understand that the Authorizations and Irrevocable Assignments contained in this document apply to all treatments at Texas Pain Centers ("TPC").
2. I agree to be responsible for the payment of all charges that result from the care provided to the patient. I also understand that I may be responsible to pay for services that are not covered by my plan, and in some circumstances, for services that are covered by my plan. I understand that this means that I promise to pay Texas Pain Centers in return for the care and services that will be provided to the patient.
3. I hereby irrevocably assign and transfer to TPC all right, title and interest in any benefits payable and all causes of action against all insurance companies, employee benefit plans, third party administrators and/or other person or entities responsible for the payment of benefits ("Responsible Parties") for all treatment provided by TPC, and I hereby appoint TPC as my attorney in fact, with power of substitution to sue or otherwise obtain payment of benefits from the Responsible Parties. This irrevocable assignment and transfer shall be for the purpose of granting TPC an independent legal right of recovery against such Responsible Parties, but shall not be construed to be an obligation of TPC to pursue any such right of recovery.
4. I understand that there may be professional / technical fees associated with the patient's care and that those fees may be billed separately by the persons or organization who provided the services. I irrevocably assign and transfer all right, title and interest in any benefits payable and all causes of action against all Responsible Parties to any physicians, caregivers, or other provider of services who are not employed by TPC and whose services will be billed separately for all treatment provided.
5. I understand that if the patient's insurance requires pre-authorization for admission of services, it is my responsibility to notify the appropriate certification area. I understand that if the pre-authorization is not obtained, a penalty can be applied by the insurance company causing a reduction in the patient's benefits.
6. I understand that TPC assumes no responsibility for personal possessions brought to its premises that belong to the patient, patient's family or any guests.
7. Pursuant to federal and state law, the undersigned consents to the use and disclosure by TPC and/or the patient's care provider of portions of the patient's record, including medical records (including psychiatric, drug and alcohol abuse information, genetic testing information, and the results of specific laboratory tests, which may include HIV or AIDS diagnosis), to any person or entity that is or may be responsible for all or any portion of TPC's and/or the provider's charges, including but not limited to insurance companies, health care service plans, workers' compensation carriers, medical or utilization review organizations of the foregoing, or to any other person or entity as necessary in connection with such payments or reimbursement. The undersigned also agrees that the center and/or the patient's provider may obtain from any source and examine and use, or discuss and disclose, the patient's medical record and information (including medical history, examinations, diagnoses, treatments, any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information) to treating medical personnel and agents, other health care providers, medical record auditors, professional committees, care evaluators and governmental agencies in order to treat the patient or for TPC to carry out its operational duties. This consent to release and obtain information is valid until revoked, and the undersigned may revoke the consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent.

Please sign in the appropriate area below:

Signature of Patient/Parent/Guardian: _____ Date: _____

Printed Name of Patient/Parent/Guardian: _____ Relationship to Patient: _____

Patient is: ☐ minor ☐ unable to sign because: _____

Witness: _____ Date: _____

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CONSENT FOR TREATMENT

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I hereby voluntarily consent to such medical care and treatment, including any diagnostic procedures and tests, to be performed on the patient named herein that the patient's physician, his or her associates, assistants and other healthcare providers believe are necessary for the care of the patient.

I hereby state that I have the legal right to consent to the medical and surgical treatment of the patient listed herein. In the course of treatment, I understand and acknowledge that no warranty or guaranty will be made as to the result or cure of treatment.

I acknowledge that administrative data, demographic information and other health information describing patient care, services and outcomes are collected and used for healthcare operations, governmental and non-governmental reporting (if required), and comparisons of Texas Pain Centers ("TPC") with other health care entities. In some instances, performance data is aggregated and reported. In every instance, patient and physician anonymity is maintained. TPC will ensure that the confidentiality and privacy of patient information is maintained.

I acknowledge and understand that each physician providing services at TPC including those physicians who may be called upon to provide care either directly (as consultants) or indirectly through professional services (i.e., radiology, pathology, EKG interpretation, anesthesiology), are independent contractors who are self-employed and are not the agents, servants or employees of TPC. I understand that for emergency or unscheduled services, TPC may aid my selection of physicians by an established "on-call" roster provided through an inpatient / outpatient care facility (e.g. Hospital, Ambulatory Surgery Center) and these physicians also are independent contractors who are self-employed and are not the agents, servants or employees of TPC. I further agree that TPC is not responsible for the judgement or conduct of any of these physicians.

I consent to the taking of photographs or films related to the care, treatment, and services provided or other internal purposes, such as performance improvement or education, and understand that such photographs or films may be made part of the medical record.

TESTING IN EVENT OF HEALTHCARE WORKER EXPOSURE

I understand that in the event that a healthcare worker is accidentally exposed to the patient's blood or bodily fluids in such a fashion that the healthcare worker may be at risk for contracting Hepatitis B, Hepatitis C, or AIDS, pursuant to Texas law, I will be required to have blood tested to determine the presence of Hepatitis B or C surface antigen and/or Human Immunodeficiency Syndrome (HIV) antibodies. I understand that these tests are performed by withdrawing a small amount of blood and using substances to test the blood.

I acknowledge that these tests may, in some instances, indicate that a person has been exposed to these viruses when the person has not (false positive) or may fail to detect that a person has been exposed to these viruses when the person actually has been exposed (false negative). I understand that if any test is positive, I will receive counseling about the meaning of these tests as it relates to the herein-named patient's healthcare.

I understand that these test results will be kept confidential to the extent allowed by law and that unauthorized distribution of these test results is a criminal offense under state law.

Please check the appropriate boxes below:

☐ The Patient/ Parent/ Guardian has received a patient information packet, including Patient Rights and Responsibilities.

The patient has an Advance Directive: Yes ☐ No ☐

If yes, check all that apply: Directive to Physicians ☐ Medical Power of Attorney ☐ Out or in Hospital DNR ☐

Please communicate the existence of any advance directive to your health care provider, and provide copies for the medical record.

☐ A translation of this form into _____(name of language) was provided by _____(name of translator)

Please sign in the appropriate area below:

☐ I have had the opportunity to read this form and ask questions about it.

Signature of Patient/Parent/Guardian: _____Date: _____

Printed Name of Patient/Parent/Guardian:_____ Relationship to Patient: _____

Patient is ☐ a minor ☐ unable to sign because:_____

Witness: _____Date: _____