Pain Specialists of Texas, 1759 Broad Park Circle South, Suite 101, Mansfield, TX 76063

CONSENT, ASSIGNMENT AND RELEASE:

I am presenting myself to Pain Specialists of Texas (**PSTX**) for evaluation, diagnosis and/or treatment of my medical condition(s). I give my consent for my physician(s) or his designees to order and/or perform all exams, tests, procedures and other care deemed necessary or advisable for the evaluation, diagnosis and treatment of my medical condition(s). 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 fluids; 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 and other information about me to release to the Social Security Administration or intermediaries or carriers information needed for any Federal and State program related to claims. I request that payment of authorized benefits be made to **PSTX** on my behalf. I understand that I am personally responsible for all deductible and co-insurance amounts under these programs.

I hereby authorize all insurance benefits otherwise payable to me to be paid directly to **PSTX**. 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 deferred to attorneys or collection agencies, I will pay all charges that are my obligation, along with reasonable attorney's fee and other collectible expenses.

I also authorize **PSTX** to release information to secure payments on my behalf. I authorize the use of my signature to be used on all insurance forms.

Signature of patient _____ DATE_____/_____/201____

Signature of authorized party, if not patient _____ DATE_____/_____/201____

PAIN SPECIALISTS OF TEXAS INFORMATION RELEASE AUTHORIZATION

It is the office policy of **PSTX** 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 _____-_____-_____ x_____ 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 below:

Name Relationship Limitations on releasing information

_____

_____

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