Specialized Medicine

BOLTZ

PAIN AND WELLNESS CENTER

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I , authorize Boltz Pain Center, LLC to perform treatment.
I, consent to Boltz Pain Center, LLC use and disclosure of all individually identifiable personal, health, financial, demographic information (Protected Health Information or PHI) for the purpose of:

- Providing medical treatment
- Obtaining payment and reimbursement
- Obtaining authorizations from my insurance for tests (where required)
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical treatment
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me (reminders, messages)

Above purposes and all others are known collectively as Treatment, Payment and Other Healthcare Operations or TPO as information may include or be related to psychiatric or psychosocial impairments, substance abuse, human immunodeficiency virus (HIV), HIV related opportunistic infections or pregnancy. You may review or receive a copy of our Notice of Privacy Practices upon request.

I, AUTHORIZE any physician or healthcare facility to provide upon request and PHI to Boltz Pain Center, LLC need for the purpose of TPO.

I, CONSENT to Boltz Pain Center, LLC discussing any or all of my medical care including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, human immunodeficiency disease (HIV), related opportunistic infections, or pregnancy with the following contacts.

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

I have been given the opportunity to review and agree with the terms and conditions of Boltz Pain Center, LLC's Health Information Protection Plan
I understand my rights to restrict the use and disclosure of PHI and to revoke this consent anytime in writing.
I understand that should I choose not to consent to the terms and conditions of Boltz Pain Center, LLC's Patient Information Protection Plan, the practice has the right to and will withhold treatment except required by law.

Patient Name: _____ Date: _____

Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Health Insurance Portability and Accountability Act of 1996 prohibits the use of disclosure of protective health information, payment, and other healthcare operations without a signed consent and prohibits the use and disclosure of protective information for non-healthcare related activities without specific and explicit authorization.

Missed Appointments
If you need to cancel an appointment, please call and cancel at least 24 hours in advance. If you miss an appointment you will be charged a $30.00 fee. No exceptions. Thank you for your cooperation.

Signature _____ Date _____