Advanced Pain Control, Ltd.

HIPPA & Consent for Treatment Form

I understand as part of my healthcare, Advanced Pain Control Ltd., originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and plans for future care or treatment. I understand this information serves as:

- A basis for planning my care treatment;
- A means of communication among the health professionals who contribute to my care;
- A source of information for applying my diagnosis and health information for billing purposes;
- A means by which a third-party payer can verify that services billed were actually provided;
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand I have the right to review the complete notice of consent prior to signing this consent. I understand the organization reserves the right to change their notice and practices at any time and I may request a copy of any revised notice by contacting Advanced Pain Control Ltd., at # 314-729-0707 or toll free # 877-728-0707.

I understand 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 organization is not required to agree to the restrictions requested. I understand I may revoke this consent by contacting Advanced Pain Control, Ltd., and requesting a Revocation of Consent Form. I understand revoking my consent does not affect disclosures already made in reliance of my prior consent.

This consent is given freely with the understanding that any and all records whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization except as authorized by law. A photocopy or fax of this consent is as valid as the original.

________________________________	________________________________
PRINT Patient's Name	Date
________________________________	________________________________
Patient **SIGNATURE** (or personal representative)	Date of Birth

In addition, I, ______________________________, authorize Advanced Pain Control, Ltd., to release any and all personal health information to the following individual concerning my status as a patient and/or regarding my treatment or payment.

________________________________	________________________________
NAME	RELATIONSHIP to patient

<u>CONSENT FOR TREATMENT:</u>

I acknowledge that I am here for treatment as will be explained to me by the physician.

________________________________	________________________________
Patient **SIGNATURE** (or personal representative)	Date