2105 Braxton Lane, Suite 101 • Greensboro, NC 27408
4590 Premier Drive • High Point, NC 27265
Phone: (336) 333-6306 • Fax: (336) 333-6309

PATIENT CONSENT

Patient Name: ______________________________ **Date of Birth:** ______________________

By signing this consent you are giving the providers and office staff permission to use and disclose your health information. Your health information will be used and disclosed to provide care and treatment; to bill and collect payment for the services provided and to perform necessary routine office operations.

You have been provided with a copy of our "Notice of Privacy Practices" that contains a complete description of the uses and disclosures covered under this consent. You have been given time to review the "Notice of Privacy Practices" and we have encouraged you to read it and ask any questions that you may have prior to signing this consent.

Our office reserves the right to change the privacy practices as stated in the "Notice of Privacy Practices". You will be given a copy of the revised notice at your first office visit following any changes. You may request a copy at any time.

You have the right to request that we restrict how your health information is used or disclosed. We are not required to agree to your requested restriction, however if we do agree to the restriction, we will honor the restriction.

You have the right to revoke this consent except to the extent that we have already taken action covered under this consent. If you choose to revoke this consent you must do so in writing.

CONSENT TO TREATMENT, RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS TO: SPINE & SCOLIOSIS SPECIALISTS

The undersigned makes the following acknowledgments and agreements regarding treatment to be provided to the patient whose name appears above.

1. **Consent to treatment:** I consent to any medical or surgical treatment rendered to the patient under the general or special instructions of the physician. I certify that no guarantee or assurance has been made as to the results which may be obtained.
2. **Release of Medical Information:** I authorize the release of any medical information necessary to provide treatment, carry out healthcare operations, or process a health insurance claim.
3. **Assignment of Benefits:** I authorize payment of medical benefits to Spine & Scoliosis Specialists.
4. I have received a copy of Spine & Scoliosis Specialists' Notice of Privacy Practices.

Contact Information

May we call your: Home: Yes/No Work: Yes/No Cell Phone: Yes/No Leave voicemail message: Yes/No

May we discuss your health information with your: Spouse: Yes/No Parent: Yes/No Other: ______________________

Who may we release medical information including picking up prescriptions (be specific): ______________________

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This consent must be signed by the patient/responsible party and dated.

______________________________	______________________________	______________
Signature of Patient or Responsible Party	**Relationship if Not Patient**	**Date**