KANSAS PAIN MANAGEMENT
10995 QUIVIRA ROAD, OVERLAND PARK, KS 66210
Phone: 913.339.9437 Fax: 913.339.9538

PATIENT CONSENT FOR TREATMENT

TODAY'S DATE		PATIENT FIRST NAME	
DATE OF BIRTH		PATIENT LAST NAME	

Welcome to Kansas Pain Management. Please take a moment to review and sign this Consent for Treatment form.

We regret that we are unable to accept any alterations to this form and will not be able to provide health care to you if the form is not signed as presented. Kansas Pain Management reserves the right to make changes to this form. If changes are made, you will be presented with a new form for signature. Our clinic staff is available to answer any questions you may have.

PATIENT'S RIGHTS AND RESPONSIBILITIES

Kansas Pain Management acknowledges that I have rights as a patient, and I acknowledge that I have responsibilities as a patient. These are discussed in the Patient Rights and Responsibilities and the Notice of Privacy Practices documents; copies are available to me upon request. I acknowledge being offered these documents.

CONSENT FOR TREATMENT

I, ____________________ voluntarily present to Kansas Pain Management for medical and surgical evaluation, diagnosis, and/or treatment. I consent and authorize my provider (or his or her designee(s) to provide diagnostic and therapeutic treatment, which may be necessary or advisable in their professional judgment. By signing this consent form, I do not waive my right to refuse recommended tests or treatment(s).

PAYMENT FOR SERVICES AND ASSIGNMENT OF BENEFITS

I understand that, regardless of my assigned insurance benefits, I am financially responsible for payment of services rendered to me. In addition, I will be financially responsible for my spouse and my child/children that is/are born or treated by Kansas Pain Management or its physicians. If the providers involved in my care accept third-party reimbursement for all or part of the services I receive, I hereby agree to assign such benefits to Kansas Pain Management and authorize my insurance company, governmental program, or other
entity to make payment directly to Kansas Pain Management. I understand that Kansas Pain Management may disclose a limited amount of health information to third-parties to obtain payment for the health care services provided. I authorize Kansas Pain Management to communicate with any pharmacy regarding my prescription medication information including prescription history and benefits. I consent to electronic transmission of prescription information and any necessary communication with my pharmacies.
I agree to pay co-payments, co-insurance, deductibles, and outstanding balances. Kansas Pain Management will honor any arrangements and/or agreements entered into with my insurance company or third-party payers. I understand that I will not be billed for amounts which Kansas Pain Management is contractually or legally obligated to discount. If I am injured and receive treatment at Kansas Pain Management, I agree to assign to Kansas Pain Management my interest in any lawsuit or settlement to the extent necessary to fully pay Kansas Pain Management for this treatment. If my account becomes delinquent and is referred to an attorney or collection agency for collections, I agree to pay reasonable and necessary attorney's fees and collection expenses.
I certify that the information given by me in applying for payment under any medical insurance program, including Medicare and Medicaid, is correct.

PATIENT PRINTED NAME		**DATE**	
PATIENT SIGNATURE			
***LEGAL REPRESENTATIVE'S PRINTED NAME**		**RELATIONSHIP TO PATIENT**	
***LEGAL REPRESENTATIVE'S SIGNATURE**		**DATE**	

Note: Proof of legal authority may be required for legal representatives.

***If signing as the legal representative, I represent to Kansas Pain Management that I am the legal representative of the patient and agree to provide proof of legal representation, if requested. Should my legal authority terminate, I agree to provide written notification to Kansas Pain Management.**

*** The owners/ employees of Anesthesiology Professionals, PA may have an ownership interest in facilities that patients are referred to for further treatment, including diagnostics and procedures. You as the patient has the right to go to any facility of your choice without any negative impact on your treatment at Anesthesiology Professionals, PA. Please talk to our office manager if you have any question or if you would like to receive a list of alternative facilities.**