Kansas Center for Pain Relief

PATIENT CONFIDENTIALITY

I hereby authorize the release of medical information to: Relationship:

I hereby authorize the Kansas Center for Pain Relief to leave information on my voice mail (circle):

Home Office Phone Cell Phone

My preferred method of communications (circle):

Text Email Voice Mail

Cell Phone #: _____ Email: _____

Patient Signature: _____ Date: _____

STATEMENT OF FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFIT: I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of the Kansas Center for Pain Relief, LLC. I assign and authorize payments to the Kansas Center for Pain Relief, LLC. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or state or federal law.

Patient Signature: _____ Date: _____