Patient Name _____

PATIENT CONSENT TO TREATMENT

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following:

1. INDEPENDENT CONTRACTORS: SOUTHLAKE PAIN CENTER may utilize independent contractors for office, outpatient or inpatient treatment/procedures. These include, but are not limited to, surgical assistants, physical therapists, and consulting and referral physicians. Healthcare professionals that are independent contractors are not agents or employees of SOUTHLAKE PAIN CENTER are responsible for their own actions. I understand that shall not be liable for the acts or omissions SOUTHLAKE SPORTS & SPINEof independent contractors. This Consent to Treatment also applies to any independent contractor utilized by my physician(s).

2. VALUABLES: SOUTHLAKE PAIN CENTER assumes no responsibility for, and I hereby release SOUTHLAKE PAIN CENTER/ ERIC I. RAY, M.D. from liability for, loss or damage to any of my personal property while on the premises and/or receiving treatment.

3. AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS: I hereby expressly authorize / SOUTHLAKE PAIN CENTER/ ERIC I. RAY, M.D. and all healthcare professionals providing care to release all necessary information to SOUTHLAKE PAIN CENTER/ ERIC I. RAY, M.D. any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to SOUTHLAKE PAIN CENTER/ ERIC I. RAY, M.D. and all professionals (including independent contractors) providing for such care, and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation SOUTHLAKE PAIN CENTER/ ERIC I. RAY, M.D. and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.

4. PAYMENT FOR SERVICES: In return for services to be provided by SOUTHLAKE PAIN CENTER/ ERIC I. RAY, M.D., I promise to pay for services rendered by SOUTHLAKE PAIN CENTER / ERIC I. RAY, M.D. to me or for my benefit. If the services I receive from SOUTHLAKE PAIN CENTER/ ERIC I. RAY, M.D. are covered by a third party payor, SOUTHLAKE PAIN CENTER/ ERIC I. RAY, M.D. may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third party payor determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are received.

5. AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS: I authorize and release SOUTHLAKE PAIN CENTER/ ERIC I. RAY, M.D. and its employees and agents to take photographs, videos, x-rays, and/or other photographic, electronic or other images of me and to use them as may be medically appropriate. Such images may be used for educational or other purposes as necessary and appropriate. These images may be maintained as a permanent part of my medical record. I understand and acknowledge that SOUTHLAKE PAIN CENTER/ ERIC I. RAY, M.D.

may use cameras for security and patient monitoring, and patient confidentiality will be maintained for all such images.

6. NO GUARANTEE OF RESULTS: SOUTHLAKE PAIN CENTER/ ERIC I. RAY, M.D. physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care. I release / SOUTHLAKE PAIN CENTER/ERIC I. RAY, M.D., its physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of SOUTHLAKE PAIN CENTER/ ERIC I. RAY, M.D. or its employees, agents, representatives or assigns.

7. During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physician(s), nurses, technicians, physician assistants, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.

8. I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

9. I hereby authorize SOUTHLAKE PAIN CENTER/ERIC I. RAY, M.D. permission to release protected health information to referring doctors for treatment/plan of care.

By signing this document, I certify that I have read and understand its contents and the information provided by me is accurate and complete (including insurance information and current eligibility for benefits).

A copy of this document may be utilized the same as the original.

Patient Name: _____ Date:_____

_____
Patient/Parent/Guardian/Authorized Representative Signature

If not signed by the patient, please indicate relationship
to the patient on the line below:
_____