PAIN CLINIC OF NORTH CAROLINA

INSURANCE, MEDIATION, & YOUR CARE

INSURANCE ASSIGNMENT----------

I request that payment of authorized Medicare/Other Insurance Company benefits be made to this office/provider for any services furnished me by that party that accepts assignment/physician. All regulations pertaining to Medicare assignment of benefits apply. Patients are responsible for all deductibles of co-insurance, and non-covered services, which is the charge determination of your insurance company.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare/Other Insurance Company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

MEDIATION----------

We encourage open communication and ask our patients to sign this mediation agreement. While we do not anticipate any issues or concerns during the course of your treatment, if any arise, you (and/ or your legal counsel) and your healthcare provider (and/or their legal counsel) agree to meet with a neutral mediator and work toward a solution. Whether or not a solution is found, mediation may postpone but does not remove or block your legal rights. Importantly, you agree that any usage or inference to a "claim" will be understood and read as "potential claim" until mediation is complete. This designation allows us to begin in a less formal manner that has been shown to expedite the resolution process. Your signature on this page confirms that should a concern arise in any aspect of the care provided by this office, staff, and affiliated healthcare professionals, you agree to mediate first before pursuing legal action.

YOUR CARE----------

We want you to receive excellent care. The best way to meet this goal is good communication. Predictable outcomes depend on both doctor and patient working toward the same goals.

YOUR COMMITMENT	OUR COMMITMENT
* Ask questions and be part of your care * Be honest about your history, symptoms, and other important information about your health. * Tell your doctor about any changes in your health * Schedule accordingly based on the recommended care plan and follow your doctor's advice * Prepare for and keep scheduled visits or reschedule visits in advance whenever possible * Be respectful to office staff and healthcare providers * End every visit with a clear understanding of your doctor's expectations, and treatment goals	* Explain diagnosis, treatment recommendations, and outcomes in an easy-to-understand way * Listen to your questions and help you make decisions about the direction of your care * Keep treatments, discussions, and records private * Determine when a breakdown of the doctor-patient relationship is justification for terminating care * Determine when referral to another provider or specialist is appropriate * Share patient information with other providers involved in your healthcare, as appropriate

I certify that I have read or had read to me the contents of this form. I understand the possible advantages that compliance with professional healthcare recommendations can provide as well as potential consequences of non-compliance. I attest that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Patient or Patient Representatives Signature Date

_____ _____

Provider's or Provider Representatives Signature Date

PAIN CLINIC OF NORTH CAROLINA

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION

PATIENT NAME:_____

DATE OF BIRTH:_____

- I agree that the healthcare provider and office may communicate with me electronically at the email address below.
- I am aware that there is some level of risk that third parties might be able to read unencrypted emails.
- I am responsible for providing the healthcare provider and office any updates to my email address.
- I can withdraw my consent to receive electronic communications by calling this office.

EMAIL ADDRESS (PLEASE PRINT CLEARLY)

_____@_____

PATIENT/PARENT SIGNATURE:_____

DATE:_____