OASIS
INTERVENTIONAL SPINE CARE

CONSENT FORM

1. I, _____ am suffering from a condition requiring outpatient care, hereby voluntarily consent to the rendering of such care at Oasis Interventional Spine Care, LLC, which may include such diagnostic procedures and medical treatment as my physician or other members of the medical staff of the facility or designees consider to be necessary or appropriate.

2. I understand that the practice of medicine and surgery is not an exact science and that the results cannot always be anticipated. I acknowledge that no guarantees have been made to me as a result of examination, procedures or treatment in this facility.

3. The undersigned authorizes the release of medical information to healthcare providers, insurance companies, federal and state agencies, which may be necessary for continuity of care, and completion of medical records.

4. I hereby authorize CMS or my insurance carrier to forward payment for medical benefits for all services provided directly to Oasis Interventional Spine Care, LLC of the insurance benefits otherwise payable to me, but not to exceed the balance due to the facility's regular charges for this period of treatment. I understand that I am financially responsible to Oasis Interventional Spine Care for charges not covered by this authorization. **I understand that there will be a $30.00 fee for any returned checks.**

5. In order to submit a claim for payment to Oasis Interventional Spine Care, LLC for services covered under your policy, we must have your authorization for release of medical records to your insurance carrier. I hereby authorize release of any information necessary to file a claim with my insurance company. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

6. I understand that Oasis Interventional Spine Care, LLC will not be responsible for the loss or damage of valuables, including but not limited to money, jewelry, eyeglasses, dentures or other personal property. There is no insurance policy to cover these items. Understanding this policy, I relieve Oasis Interventional Spine Care, LLC of responsibility including financial liability of any personal holdings.

7. **I understand that if I do not call at least 24 hours in advance to cancel a scheduled appointment and fail to attend it, I will be charged a $30 no show fee. If I do not call at least 48 hours in advance to cancel a scheduled procedure at the Blue Bell Surgery Center and fail to attend it, I will be charged a $100 no show fee.** If I am 15 minutes late to an appointment, I will be asked to reschedule. If I fail to attend a scheduled appointment on three occasions I will not have the opportunity to schedule another appointment.

8. I give Oasis Interventional Spine Care, LLC consent to photograph or video record appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videos are maintained and released in accordance with protected health information regulations.

This form has been fully explained to me, and I certify that I understand its contents.

Date____/____/____ Signature_____

Witness (*If patient is unable to consent or is a minor, complete the following)*

*Patient (is a minor of _____years of age) (is unable to consent because)*_____

*Date ___/___/___ Signature of Legal Guardian or relative*_____

Witness _____

Relationship to Patient _____