360 Back and Spine Center
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GENERAL CONSENT FOR TREATMENT AND USE OF DISCLOSURE FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I _____, knowing that I am suffering from a condition requiring diagnostic or medical treatment, do hereby voluntarily consent to such procedures and care to such medial, diagnostic or other services under the general and specific instructions of 360 Back and Spine Center, its assistants or designee as is necessary in their judgment.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of the treatments or examination by 360 Back and Spine Center.

I understand that as part of my health care, 360 Back and Spine Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

I understand that 360 Back and Spine Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I wish to have the following restrictions to the use or disclosure of my health information:

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_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_____ _____

Patient's Signature Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.