MIDESSA
NEUROSURGERY & COMPLEX SPINE
Texas neurosurgery and spine destination

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CONSENT TO TREAT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I give the providers and staff of Midessa Neurosurgery and Complex Spine permission to examine and treat my condition or that of my dependent. I understand this could include physical exam, lab tests, imaging studies, Physical therapy, education or other diagnostic tests. I understand that I have the right to refuse treatment. I understand that telephone calls and office visits may be recorded.

Initial:_____

I authorize Midessa Neurosurgery and Complex to directly bill Medicare, Medicaid and other insurance on my behalf. Furthermore, I authorize Medicare, Medicaid and other insurance to pay benefits on my behalf directly to Midessa Neurosurgery and Complex Spine for items and services provided to me by Midessa Neurosurgery and Complex Spine. I agree to notify immediately of any changes in insurance coverage. I agree to pay all amounts owed to Midessa Neurosurgery and Complex Spine that are not covered by Medicare, Medicaid or other insurance, including applicable co-payments and deductibles for which I am responsible. I understand that if Midessa Neurosurgery and Complex Spine is out of network with my insurance, I have the option to get my care at either an in-network or an out of network provider. I understand that when receiving care out of network for products or services covered by my benefit plan, my insurer may impose a higher deductible and higher copayments than if I received services from a network provider. I understand and agree that I am ultimately responsible for the balance of my account.

Initial:_____

I understand that if at any time my condition is found to be work related, treatment must be authorized by my employer's Workers Compensation Carrier before any further treatment will be offered and all other necessary information concerning my condition and treatment may be released to my employer, or Workers Compensation Carrier. I also understand that if my Workers Compensation coverage is denied for any reason, or my employer fails to honor its agreement to pay my medical bills, I will be responsible for my medical bills. In consideration of services rendered, I hereby assign and transfer to Midessa Neurosurgery and Complex Spine all rights, title and interest in the benefits payable for services rendered by all of my insurers and/or employee benefit plans, as well as all claims and/or causes of action (including but not limited to breach of fiduciary duty) that I have now and may have in the future related to the failure or refusal of any such insurer/employee benefit plan to properly pay benefits when due. I hereby authorize and instruct the insurers and/or employee benefit plans to pay directly to Midessa Neurosurgery and Complex Spine all benefits due under the terms of my insurance policy or policies and/or employee benefit plans.

Initial:_____

I authorize any holder of medical or other information about me to release to Midessa Neurosurgery and Complex Spine or its billing agent any information for this and any related health claim. Furthermore, I authorize Midessa Neurosurgery and Complex Spine to release medical or other information about me for the purpose of obtaining payment from Medicare, Medicaid or other insurance and their agents and assignees. Such records may be released to any individual or entity authorized to receive such information. I agree to permit a fax or other copy of this form to serve as an original. Upon request, a copy of this form may be sent to Medicare, Medicaid or other insurance and their agents or assignees. Midessa Neurosurgery and Complex Spine will keep the original form on file. I understand that this authorization will remain in effect until revoked by me in writing.

Initial:_____

☐ I certify that I have read and understand this document.

_____
Patient Name

_____
Date

Signature of Patient / Representative