DALLAS SPINE CARE
CLINICAL AND SURGICAL TREATMENT OF THE SPINE
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ROBERT J. HENDERSON, M.D., FACS

ACKNOWLEDGEMENTS AND CONSENT FOR TREATMENT

CONSENT TO TREATMENT

- I authorize Robert J. Henderson, M.D., (or whomever he may designate as his associate or assistant) to perform examinations, injections, x-rays or other treatments deemed necessary to diagnose and treat my condition. I authorize the employees of Dallas Spine Care, P.A. (DSC) to assist my doctor in any way he deems necessary for such treatment.
- I voluntarily consent to medical treatment and understand that no guarantees are made as to the results.
- Females only – During my course and treatment, x-rays may be taken on a periodic basis. I understand taking x-rays is contraindicated (may be harmful) if I am pregnant or suspect pregnancy. I understand it remains my responsibility to inform the x-ray technician of my condition.
- Prescription medication may be given to me, and I have received a copy DSC's controlled substance agreement.

GENERAL OFFICE POLICY

- If I need to cancel my appointment, I am to call as far in advance as possible to allow another patient to be scheduled in my place. Failure to keep any appointment (without notice) on 3 consecutive occasions will result in a termination of physician-patient relationship. If I arrive more than 15 minutes late, I will either be rescheduled or asked to wait, possibly until the end of the day.
- DSC is a smoke-free facility. I will refrain from using tobacco and smoking material while on the premises, this includes the sidewalk directly in front of the DSC suite. I understand if I violate this policy I will be discharged from care.
- I understand DSC treats patients (like me) who have acute or chronic pain and that unruly or crying children can cause emotional/stressful disturbance to other patients. For this reason I am asked not to bring children to my appointment and if I violate this policy I may be asked to remove my child from the lobby. Children are not allowed in the examining rooms.
- I have been given written notice of DSC's Health Insurance Portability and Accountability Act (HIPAA.)
- I have been given a copy of DSC's policy and request for release of medical records.
- By signing this form I consent to the use of disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke consent, in writing, except where disclosures have already been made in reliance on my prior consent.
- I acknowledge that the doctor and his staff do everything possible to see me as appointed but there are circumstances beyond anyone's control that can delay my being seen by the doctor way beyond the time of my scheduled appointment.
- This consent is given freely with the understanding that: Any and all records whether written or oral or in electronic format are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as provided by law. I understand this document will be scanned into my electronic medical record, no other copy will be maintained and a photocopy or fax of this consent is as valid as its original. I have the right to request my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted, in which case the restriction is made in writing and if I agree to terminate the restriction this request will also be made in writing.

My signature below provides acknowledgement and consent.

Patient (printed name):_____

Signature: _____ Date: _____