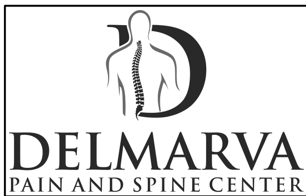

MEDICAL TREATMENT CONSENT FORM

Phone (302) 355-0900
Fax (302) 355-0901
Web delmarvapain.com

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

CONSENT FOR TREATMENT & EVALUATION

I voluntarily request that Delmarva Pain and Spine Center, LLC provide pain management care, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing, and treatment, which may include diagnostic, radiology, and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/or blood samples. I have the right to refuse specific tests, but understand this may impact my pain management treatment. If invasive interventional treatment is recommended, I will be informed of the nature and purpose of the treatment with an explanation of benefits and risks prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

CONSENT FOR PHOTOGRAPHY AND VIDEOGRAPHY

I consent to taking and reproducing pictures of me in any form (e.g. photograph, film, tape, etc.) in connection with my diagnosis, care, and treatment (including surgical procedures). These pictures will be used for purposes related to treatment, scientific, and educational purposes, billing, coordination of care, and healthcare operations, such as quality assurance, patient safety, and identification.

RELEASE OF INFORMATION

I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices, which I have full access to view. I authorize Delmarva Pain and Spine Center, LLC physicians, and/or their staff, to obtain my medication history and other relevant health care information, verbally, written, or electronically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

____

Printed Name of Patient or Representative | Relationship to Patient

X ____

Signature of Patient or Representative | Date