NOBLE
PAIN MANAGEMENT
& SPORTS MEDICINE

Patient Name: _____

Date of Birth: _____

CONSENT TO TREAT: I consent to the administration of health care by Noble Pain and sports Medicine (Noble). I understand that I may set conditions or limitations on my treatment and care and that if I wish to provide such conditions, I will be given the opportunity to write those in a separate document. I have been informed and acknowledge that I may withdraw my consent at any time upon written notice to Noble. I am giving my consent to the administration of health care by Noble voluntarily, and that hereby knowingly and voluntarily enter into this Health Care Consent for Treatment. Noble is an interventional Pain Management and Sports Medicine clinic only. Noble encourages all patients to obtain a Primary Care Physician.

AGREEMENT FOR BENEFIT ASSIGNMENT AND FINANCIAL RESPONSIBILTY: I agree to pay for all services rendered to me by a Noble Pain and Sports Medicine (Noble) physician and/or other qualified healthcare provider employed by Noble. I agree that I am responsible to provide timely information about my insurance coverage and changes in coverage as they occur. **I am responsible for keeping any required insurance referrals current and up to date**. I agree to respond promptly to requests for information from my insurance company as they occur. I assign Noble Pain and Sports management (Noble) benefits due to me or become due to me as a result of the medical services I shall receive from a Noble physician or other qualified healthcare provider. I further authorize the payments to be paid directly to Noble. I also understand that I am responsible to Noble for any payments made directly to me for services Noble provided to me. If this account is not paid in accordance with Noble's policies, I agree and guarantee to pay collection costs, including reasonable attorney fees, collection agency fees and interest from the date of demand. We also can arrange payment plans.

IF MEDICARE, MEDICAID, or other similar government program should determine that I am not eligible for coverage or that the treatment is not covered, I will be responsible for payment, unless prohibited by law.

IF NO INSURANCE, THIRD-PARTY INSURANCE, or MOTOR VEHICLE ACCIDENTS you will be responsible for all charges associated with your care. Any balance on your account is your responsibility to pay in full at the beginning of the office visit. Likewise, any associated medical procedure will require a prepayment of 100% of the physician's fee and any balance from additional services will be billed to the patient. We do not file insurance to third-parties or insurance carriers and do not accept liens. You will be responsible for all charges as well as billing appropriate carriers as you like. For the patients without insurance, we are able to offer a self-pay discount due to required payment in full at the time of service. There are no discounts for third-party carriers.

ACKNOWLEDGEMENT OF PRIVACY POLICIES / HIPAA: I have been offered a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changes at any time and I have the right to request new copies at any Noble location during regular business hours.

☐ ACCEPTED ☐ DECLINED _____ Patient's Initials

By my signature below, I am acknowledging receipt of this document and agree to the terms under all five sections of this document. Agreement Consent to Treat, Benefit Assignment and Financial Responsibility and receipt of Privacy Policies / HIPAA.

_____ _____
Name of Patient/Guardian Date

_____ _____
Signature of Patient/Guardian Date

_____ _____
Relationship to Patient if signed by someone other than patient Date