ORION
SPINE AND PAIN

Consents and agreements

Permission for Treatment

Initials: _____
I hereby authorize the physician and clinical staff of Orion spine and pain to provide evaluation and treatment to the patient named on this record. This may include examinations, diagnostic testing, and therapeutic procedures as deemed necessary in the course of care.

I understand that treatment may be rendered by the physician or other qualified medical personnel under the physician's supervision. I acknowledge that no guarantees have been made to me regarding the outcomes of any examinations or treatments performed.

Consent for E-Prescribing and Medication History

Initials: _____
I understand that as part of my electronic health record, Orion spine and pain may electronically transmit my prescriptions, as permitted by law, to the pharmacy I designate as my primary pharmacy provider.

I also understand that Orion spine and pain may obtain my prescription history from pharmacy benefit managers, including medications prescribed over the past two years. This information will be incorporated into my electronic health record to support safe and effective care.

By initialing above, I give my consent for these actions.

Authorization to Release Information and Process Claims

Initials: _____
I authorize Orion spine and pain to: (1) release any medical information necessary to process insurance claims; (2) file claims on my behalf for services rendered; and (3) use a photocopy of my signature for claim processing for the duration of my care. This authorization remains in effect until it is revoked by me in writing.

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Assignment of Benefits

Initials: _____

I authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health plan, to issue payment directly to Orion spine and pain for services rendered to me or my dependents. I assign to Orion spine and pain all rights and interests under the medical expense or PIP section of my insurance policy, including the right to pursue legal action or arbitration for unpaid or denied claims. This assignment remains valid for all administrative and judicial reviews under applicable laws unless revoked in writing.

Financial Responsibility and Insurance Policy Acknowledgment

Initials: _____

I understand that I am financially responsible for all charges for services rendered by Orion spine and pain, including any portion not covered by my insurance. Co-payments are due at the time of service, and full payment is required for non-covered services unless other arrangements are made in advance. As a courtesy, the practice will file insurance claims on my behalf; however, this does not guarantee payment. I am responsible for notifying the office of any changes in my insurance coverage and for any balances not paid by my insurer. Returned checks are subject to a $25 fee. Accounts unpaid after 90 days may incur interest and collection fees, for which I will be responsible. By initialing, I acknowledge and accept these terms.

Appointment Cancellation and No-Show Policy

Initials: _____

I understand that I must notify Orion Spine and Pain at least 24 hours in advance to cancel or reschedule a non-emergent appointment. Failure to do so, arriving 15 minutes late, or missing the appointment without notice will result in a $50 no-show fee for office visits or a $250 fee for procedures. These fees must be paid before future appointments can be scheduled. Emergencies will be considered on a case-by-case basis. Repeated no-shows (three within 12 months) may result in dismissal from the practice.