



**COMPREHENSIVE
Pain Management Center**

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CONDITIONS OF ADMISSION / CONSENT FOR SERVICES

Please read and sign the following agreement so that we may proceed with your care and treatment at the Comprehensive Pain Management Center.

CONSENT TO MEDICAL CARE: The undersigned hereby consents to the procedures that may be performed today as well as in the future during outpatient treatment, including emergency services, or other services rendered under the general and special instructions of my physician.

PERSONAL VALUABLES: It is understood and agreed that Comprehensive Pain Management Center maintains a safe environment for personal belongs. The staff shall not be liable for the loss or damage to any money, jewelry, glasses, documents, clothing, electronic devices or other personal articles of unusual value.

FINANCIAL AGREEMENT: The undersigned, whether signing as a patient or representative of the patient, agrees to pay all charges for medical services not otherwise covered by health care benefits, in accordance with the rates and terms of the Comprehensive Pain Management Center. If the account is referred to an attorney or collection agency, the undersigned agrees to pay actual collection costs, including attorney's fees, together with interest at the legal rate.

ASSIGNMENT OF BENEFITS: The undersigned, whether signing as a patient or representative of the patient, authorizes direct payment to the Comprehensive Pain Management Center of any health care coverage benefits otherwise payable to or on behalf of the patient for medical services rendered by us, including emergency services, if any. Health care coverage benefits include Medicare, Medi-Cal, other governmental health care program benefits, as well as coverage under a Workers Compensation, automobile, life/accident, and disability insurance plan. The undersigned authorizes release of medical information necessary to determine the eligibility and benefits payable and to submit and process claims for payment.

AUTHORIZES REPRESENTATIVE: The undersigned hereby authorizes the Comprehensive Pain Management Center, at its election but without obligation, to represent the patient regarding any application and appeal for eligibility and benefits pursuant to the patient's applicable health benefit plan, including Medicare, Medi-Cal, or other governmental program benefits relating to services rendered at Comprehensive Pain Management Center.

ADVANCE DIRECTIVE:

Does the patient have an Advance Directive? Yes No If yes, location: _____

ACKNOWLEDGEMENT OF RECEIPT (For Medicare patients only): My signature below acknowledges my receipt of an Advance Beneficiary Notice (ABN).

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ AND UNDERSTANDS THIS FORM, HAS RECEIVED A COPY OF IT, AND ACCEPTS AND AGREES TO ABIDE BY ITS TERMS.

Signature: (PATIENT/PARENT/CONSERVATOR/GUARDIAN/AGENT) _____

Relationship: _____

Witness: _____ Date: _____ Time: _____

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative:

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement and Assignment of Benefits provisions above.

Signature: (FINANCIALLY RESPONSIBLE PARTY) _____ Relationship: _____

Witness: _____ Date: _____ Time: _____