Axis Brain & Back Institute, PLLC

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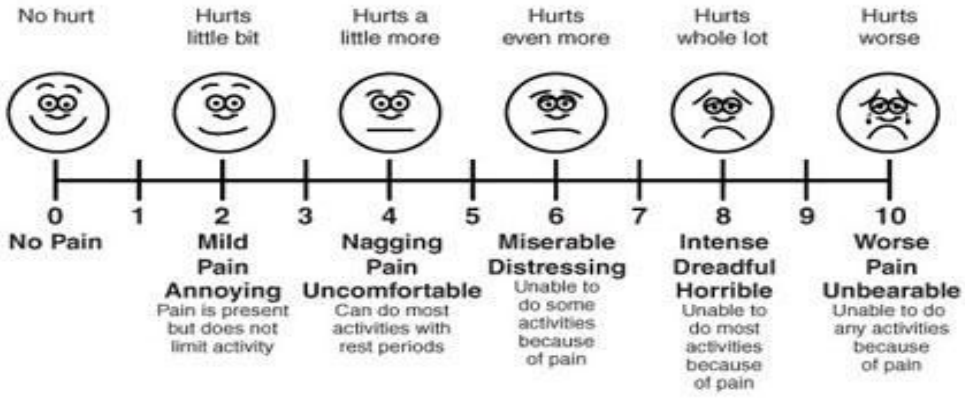

CONSENT FOR TREATMENT FORM

_____ (Initial) I understand that I have presented myself to AXBBI, PLLC for evaluation and/or treatment for my condition. I authorize and direct AXBBI, PLLC to perform quality care upon me, and understand that all options will be discussed prior to the administration of treatment. I acknowledge that the practice of medicine is not exact science and that no guarantees have been made to me as to the outcome of any procedures and/or treatments. I grant this consent without duress, confusion, or pressure from my physician and/or his/her associates, or colleagues.

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

_____ (Initial) I hereby give authorization of insurance benefits to be made directly to AXBBI, PLLC services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

ACKNOWLEDGEMENT OF PATIENT RIGHTS

_____ (Initial) I, have read the **NOTICE OF PATIENT RIGHTS** and have had any questions answered by this office. I understand that by signing this form I acknowledge that I have read the Patient Rights Notice. My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing. But any disclosures given in reliance on this prior consent will be permissible.

ACKNOWLEDGMENT OF PATIENT RESPONSIBILITIES

_____ (Initial) I have read the **NOTICE OF PATIENT RESPONSIBILITIES** and have had any questions answered by this office. I understand that by signing this form I acknowledge that I have read the **Patient Responsibilities Notice posted in all AXBBI, PLLC locations.** My consent is freely given. I understand that I may revoke this consent at any time, if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

_____ (Initial) I acknowledge that AXBBI, PLLC has provided me with the opportunity to view and read a written copy of **NOTICE OF PRIVACY PRACTICE.**

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO FAMILY MEMBERS & CONSENT OF DISCLOSURE OF INFORMATION

_____ I acknowledge that AXBBI, PLLC will disclose my protected Health Information (PHI) to a family member, other relative, close friend or any