Saeid Aryan, D.O.

David Rubin, M.D.

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CONSENT FOR TREATMENT FORM

__________ I understand that I have presented myself to AXBBI, PLLC for evaluation and/or treatment for my condition. I authorize and direct
(Initial) 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

__________ I hereby give authorization of insurance benefits to be made directly to AXBBI, PLLC services rendered. I understand that I am financially
(Initial) 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

__________ I, have read the **NOTICE OF PATIENT RIGHTS** and have had any questions answered by this office. I understand that by
(Initial) 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

__________ I have read the **NOTICE OF PATIENT RESPONSIBILITIES** and have had any questions answered by this office. I understand that by signing
(Initial) 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.

ACKNOWLEDGEMENT OF FINANCIAL INTERESTS

_________ I acknowledge that Dr. Saeid Aryan and/or Dr. David Rubin at any given time may be a consultant, owner, manager, director, or
(Initial) developer of various entities including but not limited to companies that develop, distribute, and/or manufacture spinal biologics and implants and may have financial interests in various physician owned entities including but not limited to: management companies, laboratories, medical device manufacturers, pharmacies, neuromonitoring, imaging, first assist and/or anesthesia companies, ambulatory surgery centers and/or hospitals, that may pertain to your care. Some of which may be out of network, and as a result you may receive an out of network bill. However, you have the right to choose the providers and healthcare facilities of your choice.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

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

_________ I **AGREE** and acknowledge that AXBBI, PLLC will disclose my protected Health Information (PHI) to a family member, other relative, close
(Initial) friend or any other person I identify that directly relates to that person's involvement in my care. The following are authorized person(s) who my PHI may be disclosed to: Name(s):____

□ Spouse: (____) ____-______ □ Mother/Father: (____) ___-______ □ Brother/Sister: (____) ___-_____ □ Other: (___) ____-________

_________ I **OBJECT** to the disclosure of my Protected Health Information to a family member, other relative, close friend or any other person.
(Initial)