New England Regional Headache Center
and NeuroDiagnostic Center, Inc.
85 Prescott Street
Worcester, Massachusetts 01605
(508) 890-5633

PATIENT CONSENT FORM

CONSENT FOR TREATMENT /CONSENT TO RELEASE/USE MEDICAL INFO. & AUTHORIZATION TO PAY INS. BENEFIT

CONSENT FOR TREATMENT

1 I hereby and voluntary consent to such procedures, including diagnostic procedures and medical treatment, as may be deemed necessary by my physician and his/her associates.

2. I acknowledge that no guarantees have been made to me as a result that may be obtained.

3. I understand that I may have the right to question, discuss or refuse any or all tests and/or treatment.

4. This form has been explained to me and I understand its contents.

Consent to Release Medical Information and Authorization to Pay Insurance Benefits

1. I authorize the release of any medical information necessary to process my insurance claim(s).

2. I authorize the release of any medical information to my Primary Care Physician.

3. I authorize and request payment directly to New England Regional Headache Center, Inc., of medical benefits otherwise payable to me. There will not exceed the facility. regular charges.

4. I understand that I am financially responsible to the facility for any deductibles, co-insurances or non covered service.

5. I agree that this authorization will cover all medical services rendered until such authorization is revoked to me.

6. I authorize the use of the contents of my records for educational purposes or for research activities provided that the patient identity is not revealed in conducting the study.

7. I agree that a photocopy of this form may be used in lieu of the original.

_____ _____/____/_____

Signed (Patient or representative) **Date**

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Patient=s Name (Printed)