University Pain & Spine Center
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CONSENT FOR MEDICAL SERVICES & FINANCIAL RESPONSIBILITY

I, _____ _____ ***, understand and agree that my below affixed signature*** authorizes medical treatment and outlines my patient responsibilities regarding insurance billing and payment for services rendered by University Pain Medicine Center (UPMC), University Pain & Spine Center (UPSC), New York Pain Medicine Associates (NYPMA), STEMMEE Surgical Center, and their affiliated providers and staff (hereinafter referred to as "Providers").

Consent for Medical Services: I voluntarily consent to medical evaluations, diagnostic procedures, and treatments that are deemed necessary by my treating provider(s). I understand that I may decline or revoke consent for treatment at any time. I acknowledge that the Providers do not offer emergency medical services and that in the event of a medical emergency, I should seek care at the nearest hospital emergency department.

Prescription and Insurance Authorization: I authorize the Providers to access and review my prescription history and medication records for treatment and verification purposes. I affirm that the insurance information I provide is accurate and up to date. I agree to notify the practice promptly of any changes in my health insurance coverage or benefits.

Financial Responsibility: I agree to pay all required co-payments at the time of service, as well as any charges related to unmet deductibles or co-insurance. I am responsible for any unpaid costs due to inactive coverage or incorrect insurance information, payable within 60 days of notification. If my insurance provider sends payment directly to me, I will forward it to the Providers immediately. Any unpaid balance after 60 days may accrue interest up to 3% per annum, and if unpaid beyond 120 days, the Providers may initiate collections or legal actions.

Informed Consent: I confirm that I have had the opportunity to discuss the proposed treatment plan with my provider, including the **risks, benefits, and alternatives**, and that all questions have been answered to my satisfaction. I consent to proceed with care based on this understanding.

By signing below, I confirm that I fully understand and agree to the terms outlined herein, including the designation of my Authorized Representative, assignment of benefits, and granting of access to my insurance information.

_____ _____

Patient or Responsible Party Signature | Date