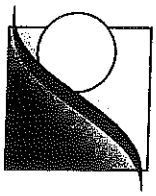

ATLANTIC PAIN MANAGEMENT & REHABILITATION, P.C.

AUTHORIZATION & CONSENT

Patient's Name_____

Date of Birth _____ MR# _____

1. Consent for Care: The undersigned patient or undersigned responsible party (hereinafter referred to as "I") grant permission to Atlantic Pain Management & Rehabilitation, P.C. to render medical treatment or diagnostic procedures as deemed necessary during care.

2. Authorization for Release of Information: I give consent for Atlantic Pain Management & Rehabilitation, P.C. to release to any insurance company with which the patient has insurance in force as well as any intermediary claims processing agency, such information which may be requested either on paper or via electronic transmission. I agree others, including physicians and hospitals involved in the medical care and treatment may have access to information at the time the patient is registered. I certify that the information given in applying for payment under TITLE XVIII and TITLE XIX of the Social Security Act, or Champus/Champus VA is correct. I authorize any holder of medical or other information to release all information needed to determine these benefits for related services. I further authorize Atlantic Pain Management & Rehabilitation, P.C. to seek funding on the patient's behalf for medical or other state funds and to make the necessary referrals, applications and requests on the patient's behalf. I authorize the Department of Social Services to release to Atlantic Pain Management & Rehabilitation, P.C. the status of any applications made by the patient or on the patient's behalf or the fact that no application was made effective today and from one year from this date. I provide the patient's social security number voluntarily and authorize its use by Atlantic Pain Management & Rehabilitation, P.C. and others providing healthcare for the purposes of identification, filing insurance claims, billing and collections, and compliance with federal and state laws. I additionally authorize any agency or person having the patient's social security number, Medicare claim number, and/or benefit information including effective date, etc. to release same to Atlantic Pain Management & Rehabilitation, P.C.

3. Authorization for Release of Pain Management Medication Information: I give consent for Atlantic Pain Management & Rehabilitation, P.C. to release and receive information regarding any pain management medication that the patient may be taking or prescribed to include pharmacies, doctors, nurses, attorneys, workman's compensation, insurance companies, and law enforcement agencies.

4. Assignment of Insurance Benefits: I hereby assign the right to all health and liability insurance benefits otherwise payable to me and authorize direct payment to Atlantic Pain Management & Rehabilitation, P.C.

5. Financial Responsibility: I understand and agree that, as the patient, or spouse of the patient, or parent of a minor child, I am responsible for payment of all charges not covered or paid within a reasonable time by any medical insurance/coverage. I also understand that what an insurance company pays is established without regard to Atlantic Pain Management & Rehabilitation, P.C.'s costs and charges. I understand that obtaining pre-certification from my medical insurance/coverage does not relieve me of my financial obligation to pay all charges if the patient's medical insurance coverage should deny coverage, fully or partially, for the treatment. I further understand that any price quotations given are based on averages and may vary significantly from actual charges, based on the physician practice patterns, secondary or tertiary medical conditions, and professional interpretations of a physician's order(s).

The undersigned, by signing this sealed document, verifies his/her understanding, agreement with, and/or consent to the above stated terms. Each of the undersigned acknowledges receipt of a copy of this document on the date he or she signed the same.

Patient's Signature: _____ Date:_____

Witness:_____ Date:_____