Our continued commitment is to provide the highest quality care in a safe, comfortable, and caring environment.

Private Patient Agreement:

I am aware that the Pain and Sleep Therapy Center is not contracted with my insurance company. I am requesting to be seen as a patient and completely understand I will be responsible for full fees on a private pay basis. I agree to pay for treatment services by the Pain and Sleep Therapy Center at the fees schedule based on the private practice charges.

HIPAA – Privacy Practices:

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis, treatment and/or fabricate an appliance necessary for my treatment.

I acknowledge receipt and agree for my information to be provided or obtained for processing of insurance claims; when releasing or requesting medical information to insurance companies or your provider needed for the processing of your claims and treatment; release and use of photographic documentation for educational and research purposes.

Telephone Consumer Protection Act (TCPA) Consent:

I give my expressed consent to Pain and Sleep Therapy Center, and any of its agents, in order to service my account or to collect any amount I owe they may contact me by telephone, at any telephone number associated with this or any other account held by Pain and Sleep Therapy Center, including wireless telephone numbers, which could result in charges to me. Pain and Sleep Therapy Center and any of its agents, may also contact me by sending text message or e-mails or pages using any e-mail address I provide to Pain and Sleep Therapy Center.

Telemedicine Encounters:

During the telemedicine encounter, details of your medical history, examinations, x-rays and test will be discussed with Pain and Sleep Therapy Center, providers, clinical assistants and treatment coordination staff through the use of interactive video, audio and telecommunication technology. A physical examination or demonstration may take place. Video, audio and or photo recording may be taken during this time for the evaluation and assessment of your TMD and/ or sleep condition(s) or symptoms associated.

I understand that payment is immediately due when services are rendered. If amounts due to the healthcare providers are not paid after reasonable notice and healthcare provider's efforts to collect, then the account will be considered delinquent – and additional service charges may be added to the account balance to offset additional incurred collection expenses. In the event that I avoid or refuse to pay or that I default on agreed payment arrangements and terms, I understand that I will be responsible for any and all reasonable attorneys' and legal fees, court costs, and incurred collection costs and expenses. If the debt is assigned to a third-party collection service, then I agree to be responsible for the collection fees and interest as allowed by Delaware statute on the outstanding debt. I understand that debts referred to a third party for collection will be reported to credit reporting entities and will be reflected in my personal credit file and history.

Cancellation/Refund Policy:

As not to delay appointments for other scheduled patients, we reserve the right to reschedule your appointment if you arrive 15 minutes after your scheduled appointment. No refunds or exchanges for completed or in-process treatment will be provided. Any refund for completed or in-process treatment is at the discretion of the Pain and Sleep Therapy Center (The Practice). In the event of a refund, the Practice shall refund to you all pre-paid fees for services not started, less any incurred laboratory fees and any discounts applied, if applicable. Any refund provided by the Practice will be in the form of a check, mailed to the guarantor of the patient account.

Our practice firmly believes that a good Doctor-Patient relationship is based on understanding and communication.

Questions regarding financial arrangements should be directed to a patient treatment coordinator within our business office.

Permission to Use Photographs & X-Rays:

I consent to the taking of photographs and x-rays before, during, and after treatment as they are a necessary part of the diagnostic procedure and record keeping. I further give permission for the use of these photographs, x-rays, and records to be used for the purpose of research, education, or publication in professional journals.

Release of Liability & Assumption of Risk - Communicable Diseases and Viral Infections:

I have been informed that receiving dental or medical services exposes both the patient and the dental providers to the possibility of spreading bacteria, viruses, infections and diseases. All patients should be aware that our office uses appropriate sterilization and personal protective equipment to minimize the possibility of spreading any bacteria or viruses, however, no guarantees can be given that I am completely safe. Many communicable diseases are easily spread when humans are in close proximity, as in a dental/medical office. Therefore, I am aware that by having any dental/medical procedure performed, there is a possibility that I could become ill.

AGREEMENT: I have been informed of the risks associated with having treatment performed. I understand that if you proceed with this treatment, I must assume all risks associated and understand that I could be exposed to bacteria, viruses, communicable diseases, and life-threatening illnesses.

ASSUMPTION OF RISK: Having been adequately informed of the risks associated with performing treatment, I freely agree to assume all risks (physical, financial or social) associated with my care, whether they currently are known or unknown. I am aware that I could have serious medical complications as a result of my dental/medical care and I acknowledge that I could become seriously ill, or even die, as a result of treatment. Therefore, I am prepared to assume all risks of this treatment.

RELEASE OF LIABILITY: Having been fully informed of the risks of care and the risks associated with bacterial and viral transmission, you hereby release the Pain and Sleep Therapy Center, LLC, and his staff of any and all liability associated with my care and agree to hold all parties harmless for any consequences with my decision.

WHEREFORE: I attest that I am fluent in English and that I have read this document. I have been adequately informed of the risks and ramifications of bacterial and viral contamination during treatment and having been given the opportunity to ask questions, and with all my questions answered to my satisfaction, I give my informed consent for treatment. I, hereby, agree to assume all risks of treatment and I agree to be responsible for any additional costs associated with this decision. Therefore, I release the Pain and Sleep Therapy Center, and staff from any and all liability associated with my care and treatment and I personally assume all risks associated with my care, including, but not limited to: respiratory infection, pneumonia, viral infection, pulmonary edema, SARS-CoV-2 (Covid-19), coronary artery disease, heart attack, stroke, cancer, atrial fibrillation, kidney failure, and increased mortality.

AUTHORIZATION AND CONSENT TO USE PHOTOGRAPH OR VIDEO RECORDINGS:

I, the undersigned, do hereby consent and agree that the Pain and Sleep Therapy Center and its employees, and/or agents have the right to take photographs, video, or digital recording of me or my dependent and to use these in any and all media, including educational materials, informational and conference presentations, social media, website, before/after photos etc.

(Mark your choice below)

☐ YES – Including full face.

☐ YES – But please exclude any recognizable facial features.

☐ NO – Photographs may only be used for medical record keeping and treatment planning only.

☐ I further consent that my name and identity may be revealed therein or by descriptive text or commentary.(Mark your choice below)

☐ YES- Use my name.

☐ NO- I prefer to remain anonymous .

☐ By signing this form below I confirm that this consent form has been explained to me in terms that I understand. I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I understand that there will be no financial or other remuneration for the recording, either for initial or subsequent transmission or playback. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

If this agreement/release is obtained from a patient under the age of 18, then the signature of the parent or legal guardian is required.

PLEASE DO NOT SIGN THIS DOCUMENT WITHOUT READING IT CAREFULLY. IT IS VITAL THAT YOU UNDERSTAND THE CONTENTS OF THIS FORM AND AGREE TO ACCEPT ANY RISKS DESCRIBED HEREIN. YOU SHOULD KNOW THAT SIGNING THIS DOCUMENT COULD AFFECT YOUR LEGAL RIGHTS.

My signature **BELOW** indicates I have read, understand, and agree to the practice policies and procedures as well as the use of photographs and x-rays and consent to the Assumption of Risk - Communicable Diseases and Viral Infections.

We assure you that Pain and Sleep Therapy Center, LLC continues to follow protocols set forth by the CDC, OSHA, ADA and IDA.

Our goal remains focused on protecting our patients, our Pain and Sleep Therapy Team, colleagues and friends/family.

We will continue to monitor new guidelines as they are released.

Patient Name (Print): _____ Date: _____

Signature: _____

Relationship: _____

Witness Name (Print): _____ Date: _____

Witness Signature: _____

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PainandSleepTherapyCenter.com
302-239-1757

RELEASE OF MEDICAL RECORDS

I, _____ [Patient Full Name] _____,[Date of birth] hereby authorize Pain and Sleep Therapy Center to release my medical records as described below:

Information to be Released:

- Entire Medical Record
- Lab Results
- Imaging Results
- Specialist Reports
- Other: _____

Purpose for Release:

- Continuity of Care
- Second Opinion
- Legal Matters
- Personal Use
- Other: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I need not sign this form in order to ensure treatment. I understand I may view or copy the information described on this form. If I have questions about disclosure of my health information, I can contact the appointed official.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

The medical provider will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I provide authorization for the requested disclosure.

Signature: _____ Date: _____

Print Name: _____