Helix Pain Solutions
851 Meadows Road. Suite 212. Boca Raton. Florida – 33486
Office: 561 392-1979 Fax: 561 392-9707

General Consent and Authorization for Treatment, Evaluation, and Information Release

Consent for Treatment

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. The consent will remain fully effective until it is revoked in writing.

You have the right to discontinue services at any time.

I certify that my Medical History is complete and accurate to the best of my knowledge and ability.

I voluntarily request that Helix Pain Solutions provide pain management care, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing and treatment which may include diagnostic, radiology and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/or blood samples. I have the right to refuse specific tests, but understand this may impact my pain management treatment. If invasive interventional treatment is recommended, I will be informed of the benefits and risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

Off-Label Pain Treatment

All prescription drugs in the United States have a label approved by the United States Food and Drug Administration. This label provides an indication and dosing for the drug, but neither patient nor physician is legally bound to follow them. Pain treatment is virtually impossible unless the physician prescribes one or more medications that are not intended for a specific indication or dosage not listed on the drug label.

I acknowledge that pain control cannot be achieved without off-label use of one or more drugs. Furthermore, I accept all risks and complications that may occur from off-label use, since the benefit of pain control cannot otherwise be achieved. I agree to waive all liability against the physician and clinic that provide pain treatment.

Any and all off-label use of drugs are covered by this consent including, but not limited to the following:

1. The uses of antidepressants, anti-epileptics, muscle relaxants, tranquilizers, and nutriceuticals for pain relief.
2. The administration of sustained release preparations of morphine and oxycodone used more frequently than every 12 hours.
3. Maximal dosage of opioids is to be determined by therapeutic effect rather than any arbitrary published maximal dosing level.
4. Topical use of morphine, methadone, naloxone, carisoprodol, and ketamine.

I agree to the above and release the physician and clinic of all liability for off-label use of drugs.

Photographs

I consent to taking and reproducing pictures of me in any form (e.g., photograph, film, tape, etc.) in connection with my diagnosis, care and treatment (including surgical procedures). These pictures will be used for purposes related to treatment, scientific and educational purposes, billing, coordination of care, and healthcare operations, such as quality assurance, patient safety and identification.

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Release of Information

I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices provided to me. I authorize Helix Pain Solutions physicians, and/or their staff, to obtain my medication history and other relevant health care information, verbally, written or electronically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

By signing below, I am agreeing to the consents and released as described on this form. I have read this consent and have been given an opportunity to ask questions.

Patient Signature	Date
Printed Name	