

Assignment of Insurance Benefits, Release of Protected Health Information, Consent For Treatment, Guaranty, And Statement of Service

I hereby assign and authorize payment made directly to Advanced Pain Care, of all of my covered health insurance benefits, including Medicare, Medicaid, Medigap, HSA, commercial, all third party payors, or private managed care plans and insurance, whether payable directly to me by any or all third party payors. I understand my health insurance plan or third party payors may not cover part or all of the medical services rendered. **I fully understand I am financially responsible for and agree to pay all charges not paid by my health insurance plans or payors, including deductibles and co-insurance regardless of reason given for non-payment. I agree to immediately forward all payments, explanations of benefits, and correspondence sent directly to me from any and all third party payors related to care rendered by Advanced Pain Care and agree that failure to do so will make me responsible for the entire billed charge.** My assignment of benefits covers Advanced Pain Care physicians and surgical center for all services now rendered and to be rendered in the future until this assignment is revoked. This assignment of benefits **supersedes** any previous assignments or agreements I made with my insurance company, including Blue Cross Blue Shield and their related companies or any other third party payor to pay me directly. A copy of this form shall be considered as valid as the original. I have received a copy of Advanced Pain Care's patient information brochure.

I understand Advanced Pain Care, is a licensed surgical center and multi-specialty clinic and files claims on my behalf as a courtesy. I agree that I am financially responsible for any facility fees, laboratory test charges, and x-ray charges incurred on my behalf for care rendered. These charges will be in addition to charges for the care that the physicians at Advanced Pain Care provide. I further understand I may receive separate bills for each of these services, and that I am financially responsible for any services not covered by third party payors, including but not limited to my health insurance and/or managed care plans. I acknowledge some or all of my care, including surgical center facility fees, laboratory testing, x-rays, CT, DEXA, MRI, and physician services may be provided by out-of-network providers, and that I am financially responsible for any increased co-pays, deductibles, and non-covered services provided on an out-of-network basis.

I have disclosed the names of all my health insurance plans and third party payors, including secondary plans, and I represent such health care coverage is in full force and effect at this time. I also agree to promptly notify Advanced Pain Care, of any change in my health insurance plan and/or coverage as well as any changes in my address and phone number. I understand that my failure to do so may make me fully responsible for the entire bill. In consideration of the services furnished to me, I hereby agree to pay any balance due **within thirty (30) days** from presentation of my bill. If my account should become delinquent, and collection efforts become necessary, I agree to pay 1% per month delinquency charges and any reasonable collection and/or attorney fees incurred. I further agree that TRAVIS COUNTY, TX will be the venue for any collection efforts including small claims court and for any and all other litigation required to collect amounts due.

I understand it is ultimately **my responsibility** to obtain all required authorizations and/or precertifications for medical services that are required by my health insurance plan and/or third party payors. I acknowledge that this is **not** the responsibility of Advanced Pain Care. **I also acknowledge no guarantees have been made by any employee of Advanced Pain Care or any other party about: (1) my treatment; (2) whether it will be paid for by any third party payor(s) or health insurance plans; or (3) whether any care rendered by Advanced Pain Care including but not limited to physician services, radiology services, and surgical center fees are in or out of network with my insurance plans.** I agree to **fully cooperate** with Advanced Pain Care to assist in their efforts to get claims paid on my behalf but understand that ultimately I am financially responsible for, and agree to pay, and unconditionally guaranty payment, of all charges not paid by my health insurance plan or third party payors.

I also authorize the release of protected health information as may be required for: (1) my treatment; (2) to process insurance claims; (3) to answer any inquiries from third parties that result from actions initiated by the patient; and (4) to support the operation of this medical practice. It is expressly understood this information will be used only for these purposes. **I acknowledge that I have had an opportunity to review and ask questions regarding the HIPAA privacy notice. I understand that I have the right to refuse treatment, to refuse to allow the participation of students in my care, or to refuse to participate in experimental research.**

I have read the above and consent to the terms and conditions stated.

Signature(s) of patient and/or insured

Date

Patient's social security number

Patient's date of birth