Patient Name: _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

[ ] Work Injury/workers comp. [ ] Auto incident/Auto insurance [ ] Other

If this is an accident-related injury, you must fill out the accident form.

If insurance, please present **ALL** insurance cards and I.D. card

Primary Ins. _____

Policy # _____

Relationship to insured: SELF SPOUSE CHILD

Primary insured's Name: _____

Primary insured's D.O.B. _____

SS# (IF required by insurance) _____

Secondary Ins. _____

Policy # _____

Relationship to insured: SELF SPOUSE CHILD

Primary insured's Name: _____

Primary insured's D.O.B. _____

SS# (IF required by insurance) _____

_____ Int. I authorize Advanced Spine and Health Center to call my insurance company and verify the benefits I have available to me under my current insurance plan.

_____ Int. I do **NOT** authorize Advanced Spine and Health Center to Contact my insurance company, nor do I authorize the release of my medical information, pertinent to my case, to my insurance company.

And

_____ Int. I hereby instruct and direct the payment of all professional and medical expense benefits allowable and otherwise payable to me under my current insurance policy to Advanced Spine and Health Center as for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a certain manner, any balance of said professional charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. I understand that I may choose to revoke this at any time in writing.

_____ Int. I have **NOT** authorized Advanced Spine and Health Center to contact my insurance nor release of Pertinent medical information **hereby agreeing to pay any balance of Professional charges privately.**

I understand and agree that the health and accident insurance policies are an arrangement between an insurance company and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the doctor to treat my condition as he deems appropriate through the use of manipulation of my spine. It is understood and agreed the amount to be paid to the doctor. XRAYS are for examinations only and the negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including but not limited to; interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

X_____

Patient or Guardian Signature Date