ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF PROTECTED HEALTH INFORMATION, CONSENT FOR TREATMENT AND GUARANTY

Thank you for choosing the Kansas Center for Pain Relief as your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies please do not hesitate to ask an administrative consultant. We ask that all patients read and sign our Financial Policy prior to seeing a medical care provider.

This document covers Kansas Center for Pain Relief (herein referred to as "Providers") for all services now rendered and to be rendered in the future until this document is revoked in writing. I hereby assign and authorize payment made directly to Providers of all my covered health insurance benefits, whether from but not limited to Medicare, Medicaid, HSA, commercial, auto, private managed care plans, insurance and all other types of Third Party Payors (herein referred to as "Third Party Payor/Payors"). This assignment of benefits supersedes any previous assignments or agreements I made with my insurance company or any other Third Party Payor to pay me directly. I agree that any payments sent directly to me are the property of Providers. I agree to immediately forward to Providers all payments, explanations of benefits, and correspondence sent directly to me from all Third Party Payors related to the care rendered by Providers, and I agree that failure to do so will make me responsible for the entire billed charges (unless there are contractual obligations between Provider and Third Party Payor disallowing balance billing). I authorize Providers to endorse on my behalf any payments I forward to them or that they receive from Third Party Payors. A copy of this form shall be considered as valid as the original.

I understand my Third Party Payors may not pay for my care (it is up to me to follow the terms of my insurance policy or program to see that the Provider is paid) and that **I am financially responsible for and agree to pay all charges not paid by my Third Party Payors, including but not limited to deductibles and co-insurance, unless there are contractual obligations between Provider and Third Party Payor disallowing balance billing.** I agree that my treating physician and I, rather than my Third Party Payor, are in the best position to determine the medical necessity of my treatment and by my receiving such treatment that I am indicating my agreement as to the medical necessity of said care. I therefore agree that any medical necessity decision by my Third Party Payor shall not constitute a reason for my non-payment of monies owed for treatment that I have already agreed to and received.

I am financially responsible for any increased co-pays, deductibles, and non-covered services provided on an out-of-network basis. I understand it is my responsibility to obtain required authorizations and/or precertifications for medical services that are required by my health insurance plan and or Third Party Payors. This is not the responsibility of my Providers. I also acknowledge that no guarantees have been made by any employee of Providers, physician or other party about my treatment or whether it will be paid for by any Third Party Payor(s) or whether Providers or my treating physicians are in or out of network with my Third Party Payors. I agree to fully cooperate with Providers to assist in their efforts to get claims paid on my behalf. It is my sole responsibility to verify the status of my healthcare benefits directly from my Third Party Payor. It is my sole responsibility to determine what portion of the care rendered by Providers will be covered by my Third Party Payors and that by receiving said care, I agree to pay any and all charges not paid for by my Third Party Payor within 30 days of receiving said care. I unconditionally guarantee payment of these charges.

I affirm that I have disclosed the names of all 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 providers of any change in my health insurance plan and/or coverage as well as changes to my address and phone number. I understand that my failure to do so will make me fully responsible for the entire bill as this is not the responsibility of my Providers. In consideration of the services furnished to me, I hereby agree to pay any balance due within thirty (30) days from the time it is processed through my insurance. In the event, it is not processed through insurance within (30) days from the time I am billed. I understand that Providers do not have to honor any limiting notations I make on a payment. If my account should become delinquent, and collection efforts become necessary, I agree to pay 1.5% per month delinquency charges and pay without challenge any reasonable collection and/or attorney fees incurred by Providers. I agree that such collection efforts may be reported to credit bureaus and may have a negative effect on my credit rating. I agree that Kansas law governs, without regard to its conflict of law principles, and Kansas will be the venue for any collection efforts and for any and all other litigation required to collect amounts due. I also authorize the release of protected health information as may be required for (1) my treatment, (2) to process insurance claims for payment of medical services, (3) to answer any inquiries from third parties that result from actions initiated by the patient, and (4) to support the business operations of the Providers. 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 and all other aspects of the billing policies and such questions have been answered to my satisfaction. I understand that I have the right to refuse: (1) treatment; (2) to allow students to participate in my care; or (3) to participate in experimental research. I consent to all tests, examinations, treatments and other services rendered to me under the instructions of all attending physicians as well as all emergency treatments and services rendered pending instructions from a physician or other licensed healthcare professional. I have received a copy of Patient Information Brochure as well as the Statement of Patient Rights and will read them. Kansas Center for Pain Relief has a physician on-call 24 hours a day 7 days a week. Should a health care emergency occur, call 911 and/or proceed to the closest emergency department. I have read the above and agree and consent to the terms and conditions stated.

_____ _____

Patient's Printed Name Date

_____ _____

Signature(s) of patient and/or insured Patient's date of birth