Valley Pain Clinic
2208 Danville Rd S.W. Suite G
Decatur, AL 35601
Phone: (256) 301-9994
Fax: (256) 301-5545

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION AND AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, **not the insurance company.** Therefore, payment for treatment is your responsibility.

Please read and sign the following:

1) I authorize this office to release or receive information necessary to expedite insurance claims.
2) I hereby authorize this office to bill my insurance company directly for their services.
3) I authorize payment directly to this physician of any insurance benefits otherwise payable to me.
4) In the event I receive payment from my insurance carrier. I agree to endorse any payment I receive over to my physician for which these fees are payable.

I understand that I am directly and fully financially responsible to this physician for charges not covered by my insurance. I further understand that such a payment is not contingent on any settlement, judgment or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payments made within **60 days,** it is **my responsibility** to pay my doctors bill directly.

I further understand and agree, and if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

There will be a $30.00 charge on all returned checks and a $10.00 charge on all delinquent accounts, which must also be paid.

A photo static copy of these authorizations and agreement shall be as valid as the original.

Signature _____
Date _____
Witness _____

Valley Pain Clinic

Health Information Consent and Acknowledgement of Notice of Privacy Practice

Consent to medical treatment:
I hereby consent to the rendering of medical care which may include diagnostic procedures, medical treatment and possible hospital admission as considered necessary by Physicians and members of medical staff.

Release of Health Information:
I authorize that my health information may be released to requesting insurance companies and/ or other physicians, or medical facilities. This includes medical history, mental and physical condition, diagnosis, prognoses treatment, and reviewing necessary x-ray, lab results, etc…

I understand that Valley Pain Clinic uses and discloses patient health information to provide treatment, to obtain payment, and for health care operations, including administrative purposes. By signing below, I consent to such use and disclosure of the patient's health information. I also consent to the use of disclosure of patient's health information from which all identifying information has been removed.

I understand that before signing this consent, I have the right to review Valley Pain Clinic Notice of information practices for more information about how my protected health information may be used and disclosed, I understand that the information practices may change, but before doing so, a new notice will be posted in the waiting area and each examination room, I may also call the office at any time (256) 301-9994 to request a copy of the notice of information practices.

I understand that I have the right to request a restriction on certain uses and disclosures of my health information, Valley Pain Clinic is not required to agree to such restrictions, but if Valley Pain Clinic does agree, it must abide by those restrictions, I understand that I have the right to revoke this consent, in writing, except where Valley Pain Clinic has already made disclosures in reliance on my prior consent.

Payment:
Payment is required at the time of service. We will provide all the information needed to file your insurance. We will file your Medicare and any supplementary insurance after we hear from Medicare.

Insurance Payment:
I request that payment of insurance benefits be made on my behalf to Physicians of Valley Pain Clinic unless payment is made at the time of service. I understand that regardless of the assignment of benefits or what type of insurance coverage I have, I am responsible for any and all charges incurred by myself or my dependents, I also agree to pay Valley Pain Clinic the part of the fee which is not covered by my insurance plan.

I instruct my doctor to complain on my behalf to the insurance commissioner, if he deems it necessary.

Name of Patient or legal representative: _____

Date of Birth: _____ SSN: _____

Signature: _____ Date: _____