

PAIN AND HEALTH MANAGEMENT CENTER

Initials

_____ **Assignment of Benefits**

I hereby authorize payment directly to Pain and Health Management Center of all benefits otherwise payable to me, but not to exceed the total charges for the services rendered.

_____ **Authorization to Release Information**

I authorize the Pain and Health Management Center to release any and all information contained in my complete medical and billing record to:

- 1) my insurance company or its representatives,
- 2) other persons or entities financially responsible for my care or treatment,
- 3) the Medicare or Medicaid programs and their fiscal intermediaries, if applicable or otherwise required or permitted by laws, regulations, and/or
- 4) Federal or state agencies, as required or permitted by laws or regulations.

_____ **Financial Responsibility**

I understand I am financially responsible to the Pain and Health Management Center for all charges for the services rendered to me. I hereby promise to pay the Pain and Health Management Center for the services I receive.

_____ **Copies**

A photostatic copy of this authorization is as valid as the original. It will remain in effect until I submit a written request to revoke it.

My signature indicates I have read and understand all the preceding information.

Patient Name _____

Patient or Responsible Party Name _____

Signature _____ Date _____

Witness _____ Date _____

**Pain and Health Management Center
Pain & Health Center**

6560 Fannin, Suite 2002
Houston, Texas 77030

Tel: 713/790-1400
Fax: 713/790-1499

FINANCIAL POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

If we participate with your managed care plan or you have a commercial insurance plan under which you are covered, as a courtesy to you we will bill your insurance for all charges for services rendered. You are however, still responsible should the insurance not pay. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for the payment of:

- The annual deductibles
- Co-payments
- Charges for non-covered services

In the event that we are not aware of a charge that is not covered by your plan, you will be balance-billed after we obtain a denial from your insurance carrier.

Please be advised that all procedures recommended by our practice may not be covered under your plan. We make every effort to contact your insurance to verify your benefits, but in the event we are unable to reach them, or receive notice indicating the service is a non-covered service you will be responsible for your co-payments as well as payment for any procedure(s) performed.

We are Medicare participating providers, therefore we will bill Medicare directly. You will be responsible at the time of service for payment of:

- The annual deductibles
- Co-payments
- Charges for non-covered services

You will be asked to sign a Waiver of Liability Form in the event that a service is provided which we know is not covered by Medicare.

If you have no health insurance, payment is expected in full at the time of service.

In the event we receive a returned check due to insufficient funds, a fee of \$25.00 will be charged to your account and payment is due upon receipt of your statement.

For your convenience we accept Cash, Check, Visa, MasterCard, American Express and Discover.

If you have any questions, please do not hesitate to ask us. We are here to assist you any way possible.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Patient Signature (or legal guardian)

Date