Logo

Description automatically generated

ASSIGNMENT OF BENEFITS

I certify that I (or my dependent) have insurance coverage(or lien) with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and I authorize, request, and assign my insurance company(or lien) to pay directly to Medici Spine & Pain insurance benefits otherwise payable to me.

Insurance (or lien) is designed to help you meet the cost of medical services. If you gave us all the requested information, including a copy of your insurance card (or signed lien), we will submit a claim to your insurance company (or attorney) as a courtesy to you. However, your insurance is a contract between you and your carrier or employer(attorney). Therefore, the ultimate responsibility for payment rests with you.

PATIENT RESPONSIBILITY: I understand and acknowledge that I am responsible for all charges for services provided to the patient listed below which are not covered by my health insurance plan(or lien) or for which I am responsible for payment under my health insurance plan. To the extent no coverage exits under my health insurance plan (or lien), I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by insurance(or lien) when services are rendered or when I am notified of charges not covered by insurance(or lien). I further agree that, if permissible by law, I will reimburse Medici Spine & Pain for costs, expenses, and attorney’s fees that may be incurred by Medici Spine & Pain to collect those charges. This agreement will be in force until balance is paid in full for all services rendered.

I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, to my insurance company, adjuster, attorney or any other payer involved in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submission. A photocopy of this agreement shall be considered just as effective and valid as the original.

**NOTE: If my current policy prohibits direct payment to the physician, then I agree to direct all payments received from my insurance company, attorney, adjuster, or any other payer by signing the checks received over to Medici Spine & Pain for services rendered. In the event I fail to direct all payments/make all payments to Medici Spine & Pain I can be legally responsible for any and all outstanding balances, deductibles, interest, legal fees, collection costs, mediation and court costs.**

I have read the above policy and my signature below indicates that I understand and agree to this policy. Further, if I forget to have the insured/patient sign the check when leaving it at the clinic, I hereby give permission for the clinic to endorse my name to said check.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature (or responsible party if patient is a minor)

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate tests, diagnosis, analysis, and treatment. I hereby authorize the physicians and staff at Medici Spine & Pain to diagnose and treat my case or the case of my child as they deem appropriate.

The medications prescribed and clinical procedures performed are usually beneficial and seldom cause any serious problems. In rare cases, underlying physical defects, deformities, pathologies, or physiological conditions may render the patient susceptible to injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, deformities, or physiological conditions which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, and agree and acknowledge that they will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read, understand, and agree to the foregoing. If I had any questions regarding the foregoing I have asked and have received sufficient explanation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Guardian

PATIENT MISSED APPOINTMENT POLICY

It is our wish that every one of our patients receive the very best care and service possible. For that reason, it is our office policy that patients must give us at least a 24-hour notice for any appointment changes or cancellations. We also ask that if you know that you are going to be more than 10 minutes late to call and notify our staff so we can accommodate the tardiness or reschedule if need be. If you are more than 15 minutes late beyond your scheduled arrival time, you will be considered to have missed your appointment and will need to be rescheduled.

If you are unable to keep an appointment due to an emergency, please call us and let us know so we can reschedule your appointment. There is a $75 service charge for all no call/missed appointments.

I have read, understand, and agree to follow the above policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature

HIPAA/PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a Privacy Rule to help ensure that personal health care information is protected for privacy. Their Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive always to take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum information necessary only to those we feel need your healthcare information and information about treatment, payment, or healthcare operation to provide your healthcare needs.

I acknowledge that I have reviewed the Notice of Privacy Practices of Medici Spine & Pain.

(Please initial one of the following options and sign below.)

\_\_\_\_\_ I wish to receive a paper copy of the Privacy Notice.

\_\_\_\_\_ I do not request a copy of the Privacy Notice currently. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

*Answering Machine Voicemail:*

\_\_\_\_\_ Do not leave message other than to return our call \_\_\_\_\_ You may leave messages with information

*Authorization:*

\_\_\_\_\_ I authorize the following identified individuals to request my treatment records on my behalf or speak with my provider on behalf at Medici Spine & Pain:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name Relationship

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name Relationship

I acknowledge that I have received a copy of Medici Spine & Pain Notice of Privacy Practices. This notice describes how Medici Spine & Pain may use and disclose my protected healthcare information. I also understand that I may revoke this authorization at any time or receive a copy of this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Guardian Date

FINANCIAL POLICY

Thank you for choosing Medici Spine & Pain for your healthcare needs. We are committed to providing the best care possible. Please understand that payment of your bill is considered part of your treatment. The following statement explains our Financial Policy, which we ask you to *read, initial beside each policy, sign at the bottom of the page*, and return to us prior to your treatment.

\_\_\_\_\_ It is imperative that complete personal information and a copy of your current insurance card is provided prior to being seen to ensure accurate billing. **PLEASE NOTE:** If incorrect insurance information is given by the patient or patients guarantor, any denial or unpaid claim will be financial responsibility of the patient.

\_\_\_\_\_ All applicable co-pays, deductibles, and prior balance are due in full at time of service.

**Regarding Insurance:**

\_\_\_\_\_ We participate with Medicare and most insurance plans. However, you must realize that your insurance is a contract between you and the insurance company and/or your employer. While we may be a provider, we are not a party to the contract.

\_\_\_\_\_ Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary. In these instances, you will be responsible for these amounts. Some Policies have deductibles for surgical procedures. The insurance companies consider procedures such as epidurals, joint injections, or other small procedures as “surgery”. If you have a surgical deductible that has not been met and have one of these procedures, you will be responsible for payment at the time of service.

\_\_\_\_\_Please be aware that insurance companies require a co-payment to be collected for every visit with a provider, whether it be a doctor, physician’s assistant, or nurse practitioner.

\_\_\_\_\_ Our office can **NEVER** guarantee coverage for any service provided because insurance companies will not guarantee benefits until they receive the claim for services. It is important that you educate yourself about your individual insurance benefits. If you are unsure of your coverage benefits, call the customer service number on your insurance card.

**Missed Appointments:**

\_\_\_\_\_ Please help us to serve you better by keeping scheduled appointments. Appointments must be cancelled at least 24 hours in advance. Please be aware that if you no-show for your appointment or cancel your appointment within 24 hours of your scheduled appointment, unless it is an emergency you will be charged a $75.00 fee.

**Past Due Accounts:**

\_\_\_\_\_ Overdue accounts will be turned over to a collection agency. Please be aware that a $50.00 processing/filing fee as well as a fee of 40% of your balance will be added to your account.

*Example: $200 owed +$50 processing +$80(40%) =$330 will be your new account balance*

**Returned Checks:**

\_\_\_\_\_ For checks returned to us as unpaid by your bank, we will charge a $45 fee.

I have read the Financial Policy. I understand and agree to the Financial Policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature