Innovative Spine and Pain Institute
Where pain stops and life begins

7655 Five Mile Road, Suite 117
Cincinnati, OH 45230
Office: 513.624.7525
Fax: 513.624.0578

Name: _____

Date of Birth: _____

ASSIGNMENT OF INSURANCE BENEFITS

I, _____hereby authorize, request, and consent that my insurance company make payment directly to Innovative Spine and Pain Institute.
I further authorize that:

> Innovative Spine and Pain Institute may file my insurance claim.
> Their physicians release medical information as requested to third party payors as may be necessary to process the claim.

I also agree that my signature on this form will allow Innovative Spine and Pain Institute to sign my claim form as Signature on File.

I understand that a 24-hour cancellation notice is required for office visits. A fee of $25.00 will be charged in the event that I do not show for an office appointment without the appropriate cancellation notice. I understand that a 48-hour cancellation notice is required for procedures. A fee of $50.00 will be charged in the event that I do not show for a scheduled procedure without the appropriate cancellation notice. I understand that these fees cannot be charged to my insurance carrier. I understand that all "no-show" fees must be paid in full prior to my next visit.

I also agree that any medical services provided to me and not covered by my medical insurance policy may be my responsibility.

Signature of Patient or Patient's guardian:_____
Date:_____
Witness:_____