

Gateway Spine & Pain Physicians

Release of Information, Financial, & Medical Policies

Thank you for choosing Gateway Spine and Pain Physicians, LLC as your health care provider. The following is a statement of our Release of Information, Financial, and Medical Policies which we require you to read and sign prior to any treatment.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Gateway Spine and Pain Physicians rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information – For Billing Purposes

I hereby authorize Gateway Spine and Pain Physicians to release medical information to Medicare, my employer's benefits department, or my other insurance company for the sole purpose of obtaining payment for my medical care. I understand that only information pertaining to obtaining payment for my care will be released. I agree that a copy of this release may be used in place of the original.

Authorization to Release Information – For Coordination of Care

I hereby authorize Gateway Spine and Pain Physicians to release medical information to my referring physician, primary care doctor, case manager, and any other individual involved in my medical care for the sole purpose of facilitating treatment. I understand that my medical information is confidential and that I have a chance to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right, I will provide in writing to my physician and any the individuals involved in my care whom I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original. I am aware that I may request that this Release of Medical Information may be revoked at any time by providing the physician's office with a dated and signed letter.

Privacy Practice Notice

I have reviewed the Privacy Practice Notice for Gateway Spine and Pain Physicians that was provided to me. I acknowledge that the notice describes how this medical practice assures the safety of my protected health information, and also explains my rights and responsibilities to the privacy regarding the medical care that I am seeking. Our privacy Practice Notice states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy either by mail, or in person. By signing below, I acknowledge receipt of our Notices of Privacy Practices.

Payment for Medical Services

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with the business office. Necessary forms will be completed to file for insurance carrier payments. I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I will be required to pay co-payments, amounts applied to deductibles and balance of bills not paid in accordance with the benefits of my current insurance policy. If I am unable to make payments in full for my medical treatment within 30 days, I agree to call the business office and make payment arrangements. I hereby authorize payment for all medical insurance benefits which are payable under the term of my insurance policy to be paid directly to Gateway Spine and Pain Physicians LLC, or designates for services rendered. I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy. I understand that it is my full responsibility that any third party which I direct Gateway Spine and Pain Physicians LLC to bill, in the event of non-payment for whatever reasons in accordance with the benefits of my current insurance policy, I will pay immediately. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. In the event that your account is turned over to an outside collection agency, you will be responsible for an additional 30% of the balance owed and/or all attorney fees and costs incurred to collect the unpaid debt.

Authorization to Discuss Information with Designated Person

It is often difficult to reach a patient to discuss appointments, medications, and other information pertinent to our patients' care. In this, event with your signed authorization, I give Gateway Spine and Pain Physicians permission to discuss such information to a person I have designated below.

Consent to Examination and Treatment

By my signature below I attest that I am capable of reading and comprehending this form without assistance, and I have signed the form of my own free will. I agree that I have been made aware of the availability of assistance and/or an interpreter to help me in completing this form, and declined any aid.

By my signature below, I hereby authorize the physicians of Gateway Spine and Pain Physicians with the assistance of other health care providers and assistants selected by them, to provide medical care and treatment to me.

*****PLEASE COMPLETE BELOW SECTION*****

I authorize Gateway Spine and Pain Physicians to discuss any information required in the course of my treatment (when I cannot be reached) to the following designated person:

Name of Person Authorized to be reached if I cannot be contacted: _____

Relationship to me: _____

Phone Number: _____

OR

_____ **INITIAL** here if you do not wish Gateway Spine and Pain Physicians to discuss your medical information with anyone but yourself.

I have read, understand, and agree to this entire Release of Information, Financial, and Medical Policies Form.

Patient/Responsible Party Signature

Date

Printed Name