NJ Pain Care Specialists

)

Patient Name:_____ **DOB**_____/_____/_____

PAYMENT AUTHORIZATION FORM

For and in consideration of services rendered, I agree to make payment to NJ Pain Care Specialists when billed for any and all charges not covered by valid insurance benefits. I authorize payment directly to NJ Pain Care Specialists for health insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed during this period of treatment. NJ Pain Care Specialists may seek, release and verify all or part of my medical and/or financial records to any person, corporation or government agency which is or may be liable under a statute, regulation or contract to NJ Pain Care Specialists, myself, a family member or my employer for all or part of the NJ Pain Care Specialists charge.

If any of the following changes: patient's address, patient's phone number, patient's insurance information or any other information necessary for NJ Pain Care Specialists to process your medical bill, the patient must inform NJ Pain Care Specialists immediately.

In the event the provider's charges are outstanding, I hereby authorize the provider to file such claim and/or action on my behalf so that the provider may receive payment of their charges. I understand that, if the provider does not receive payment from the insurer, I remain personally responsible for payment of the provider's charges.

Medicare – Authorization to release information and payment request:
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to this or a related Medicare claim. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for physician's services to the physician or organization furnishing the services or authorize such payment or organization to submit a claim to Medicare for payment.

Please check the appropriate box: (MEDICARE CERTIFICATION)

I am entitled to benefits under Medicare Hospital Insurance, Part A.

YES _____ NO _____

I am entitled to benefits under Medicare Hospital Insurance, Part B.

YES _____ NO _____

_____ _____
Date Signature

ASSIGNMENT OF BENEFITS

I, the undersigned, as a patient of NJ Pain Care Specialists, hereby assign to NJ Pain Care Specialists any and all rights that I have to make claim and/or sue any insurance company including, but not limited to, my PIP carrier for payment of outstanding medical bills I have incurred with NJ Pain Care Specialists as a result of my accident of _____.

It is hereby understood and agreed that NJ Pain Care Specialists can retain the services of any attorney of his/her choice to institute a lawsuit in my name and on my behalf for the collection of my outstanding medical bills against_____ Insurance Company.

I further agree to provide NJ Pain Care Specialists and/or designated attorney with any help or assistance they may require to collect my outstanding medical bills.

_____ _____

Date Patient/Insured Signature

NJ Pain Care Specialists

Patient Name:_____ DOB_____/_____/_____

Please initial where applicable and sign at the bottom that you understand your responsibilities:

It is your responsibility to make sure that your accident insurance company has authorized your office visit. If your insurance company does not pay for the visit, you will be held accountable for the entire charge.

initial _____

It is **your responsibility** to adhere to all of the regulations and requirements of **your health plan,** in or out of network. If your health plan requires you to obtain a written referral and/or authorization number from your Primary Care Doctor for your office visit, **you must supply us with the referral/authorization number**. If you do not, **you will be responsible for the entire charge of the office visit**. This is a rule of the Health Plan that you selected. We will help you , but ultimately **this is your responsibility**.

initial_____

Patient's Signature _____

Date _____