NJ Pain Care Specialists			
Patient Name:	DOB	/	1
PAYMENT A	UTHORIZATION FOI	RM	
For and in consideration of services Specialists when billed for any and authorize payment directly to NJ Papayable to me under the terms of ne services performed during this periodelease and verify all or part of my corporation or government agency contract to NJ Pain Care Specialists part of the NJ Pain Care Specialists	all charges not covered by vain Care Specialists for healt my policy but not to exceed the od of treatment. NJ Pain Car medical and/or financial recombined which is or may be liable unes, myself, a family member of	valid insurate h insurate balander Special ords to a der a sta	rance benefits. Ince benefits ce due for lists may seek, my person, tute, regulation o
If any of the following changes: painsurance information or any other to process your medical bill, the painmediately.	information necessary for N	J Pain C	are Specialists
In the event the provider's charges such claim and/or action on my bel charges. I understand that, if the premain personally responsible for p	nalf so that the provider may ovider does not receive payn	receive prent fron	payment of their
Medicare – Authorization to release I certify that the information given the Social Security Act is correct. I about me to be released to this or a of authorized benefits be made on a services to the physician or organiz payment or organization to submit	by me in applying for paymed authorize any holder of med related Medicare claim. I remy behalf. I assign benefits pation furnishing the services	ent under dical or or cape the cape of the	other information at direct payment for physician's
Please check the appropriate box	x: (MEDICARE CERTIFIC	ATION))
I am entitled to benefits under Med	licare Hospital Insurance, Par	rt A.	
YES	NO		
I am entitled to benefits under Med	licare Hospital Insurance, Par	rt B.	
YES	NO		

Signature

Date

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 applic your responsibilities:	able and sign at the bottom that	you understand
company has author	lity to make sure that your accid rized your office visit. If your in visit, you will be held accountable	surance company
requirements of you health plan requires authorization numb visit, you must sup If you do not, you voffice visit. This is	pility to adhere to all of the regular health plan, in or out of network you to obtain a written referral a er from your Primary Care Doctor ply us with the referral/author will be responsible for the entire a rule of the Health Plan that you altimately this is your responsible.	ations and ork. If your and/or or for your office rization number. e charge of the u selected. We
		initial
Patient's Signature		
Date		