PainCare of San Diego A Medical Corporation

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FINANCIAL RESPONSIBILITY

_____ I have chosen PainCare of San Diego, AMC to provide medical services. I agree to be financially responsible for all of the fees charged for medical services provided that are not covered by my health insurance.

_____ I understand that I am responsible for the co-payment or deductible requirements of my insurance and for payment for any services that are not covered or are ineligible for payment by my insurance. If it is determined that I am not eligible for insurance coverage, I agree to pay the fee charged by PainCare of San Diego.

_____ I understand that if a service is provided that is not included as a benefit under my insurance coverage that I will be responsible for paying the fee charged by PainCare of San Diego.

_____ I understand I may be personally responsible for payment of services that I am electing to proceed with. I agree to pay for all services at the time of service or within 30 days of receipt of a bill as well as pay for any outstanding fees owed to PainCare of San Diego.

_____ If my appointment has been scheduled at a facility, I understand that I will receive bills for services rendered by the facility separate and apart from the physician's charges.

_____ In the event my insurance pays me directly for services rendered, I promise to immediately sign over and forward those payments to PainCare.

AUTHORIZATION: I hereby authorize payment directly to PainCare of San Diego for medical services rendered and to release any information acquired in the course of my examination or treatment to my insurance company for payment.

_____ _____ _____

Print Name Signature/ Responsible Party Date

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