



CONSENT TO TREAT

Thank you for choosing River Cities Interventional Pain Specialists 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 River Cities Interventional Pain Specialists 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 River Cities Interventional Pain Specialists 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 River Cities Interventional Pain Specialists 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 of 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.

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 billing 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, I agree to call the billing 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 River Cities Interventional Pain Specialists 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 River Cities Interventional Pain Specialists 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 required to pay your entire balance and any collection agency fees, up to 25% of the balance owed and/or all attorney fees and costs incurred to collect the unpaid debt, before being scheduled for any further appointments.

My signature below verifies that I have read and understand the *Consent to Treat* outlined above and that a copy of the policy is available to me upon my request.

Patient Signature

Date Signed