Patient Name: _____

ASSIGNMENT OF BENEFITS

I hereby authorize Gramercy Pain Management to apply for medicare/Medigap, and other health insurance benefits (if applicable, no fault and worker's compensation ...) on my behalf. I request payment of Blue Cross Blue Shield and other insurance carriers be made directly to the above provider. I certify that the information I have reported with regard to my insurance carrier(s) is correct. I authorize the release of medical information about me to my health insurance carrier and HCF A (Health Care and Finance Administration) agents, any and all other information needed to determine the benefits payable for related service(s). I hereby authorize payment of Medigap benefits be made on my behalf to the above named provider. I release any holder of Medicare information about me to my insurance carrier(s) necessary to determine benefits payable for related services.

Signature:_____ Date: _____

Witness: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Gramercy Pain Management and its associates to provide treatment and/or examination and release any information pertinent to my case in the course of my examination or treatment to my physician, insurance company, adjuster, or attorney if applicable in this case. I hereby authorize Gramercy Pain Management to obtain any medical information from my referring physician including, but not limited to clinical history and office notes.

Signature:_____ Date: _____

Witness: _____

FINANCIAL POLICY

If medical insurance information is received at the time of service, as a courtesy, a claim will be submitted to your insurance company. Insurance co-payments and annual deductibles not met for the year are payable when services are rendered. Any services that are not covered by your insurance is your responsibility and will be due and payable upon receipt of a billing statement. Should your insurance carrier deny your claim you give us the right to appeal your claim on your behalf. If the correct insurance information or referral is not presented at the time of service, you are responsible for the full amount of the charges incurred. If you do not have medical insurance, financial arrangements must be made prior to services rendered. Otherwise, full payment will be expected at the time of services. If account should become delinquent, and is forwarded to our collection agency and or attorney, the collection agency or attorney fee will be added to the balance due.

Signature:_____ Date: _____

Witness: _____