## Financial Policy and Authorization

Patient Name: ___________________________________

1. **Authorization for Treatment** – I hereby authorize the physician(s) and healthcare professionals of Indiana Spine Hospital to conduct examinations and perform procedures as are medically required, and administer such treatment and medications as deemed necessary or advisable.

2. **Release of Information/Medical Record Diagnosis** – I hereby authorize the physician(s) and healthcare professionals of Indiana Spine Hospital to release a complete report of services rendered including diagnosis, findings and details of treatment and progress for the purpose of receiving payment for the services rendered to its authorized billing agents, my insurance carrier, employer's workers' compensation insurance company, or other category of third party payer, the Social Security Administration under Title XVIII (18) of the Social Security Act, any Professional Review Organization, or other intermediaries responsible for payment of my charges. I understand that I may revoke this consent at any time by giving written notice. I understand that if I refuse to consent to the release of information, I will be held personally responsible for payment of all charges for services rendered.

3. **Authorization for Assignment of Benefits** – In consideration of medical services provided I hereby assign and transfer to the physician(s) all of my rights, title and interest to medical reimbursement in accordance with the terms and benefits under my insurance policy or other health benefit otherwise payable to me for those services rendered by my physician. I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance. I understand that if I do not pay the balance in full within 90 days, my account will be placed for collection unless a payment plan arrangement has been made, and I will be responsible for all collection expenses including reasonable attorneys' fees and court costs.

4. **Insurance Filing** – I understand that as a courtesy, Indiana Spine Hospital will file for benefits with my insurance carrier(s). I understand that fees may exceed the charges allowed by my insurance carrier. I agree to be responsible to Indiana Spine Hospital for the full balance of the charges that are not paid by my private insurance carrier including any deductible.

5. **Workers' Compensation** – If I am a workers' compensation patient, I understand I will not be balance billed.

6. **Pre-certification** – If my insurance requires pre-certification, it is my responsibility to make sure it is obtained. I will be held financially responsible if the pre-certification is not obtained.

I hereby certify that I have read and fully understand this Financial Policy and Authorization form. I also certify that no guarantee or assurance has been made as to the results that may be obtained from any treatment.

_______________________________________________ ________________
Patient Signature Date

or

_______________________________________________ ________________
Responsible Party Signature/Relationship to Patient Date