SUNSHINE SPINE & PAIN, PA

FINANCIAL POLICY AND AGGREEMENT

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered by Sunshine Spine & Pain, PA. I am responsible for any applicable deductible, co-payments and coinsurance prior to the provision of services. Sunshine Spine & Pain may file **ALL** claims for payment with my insurance company as a courtesy to me. If the insurance company fails to pay in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts due. Payments may be made in the form of cash, check, visa or mastercard. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection including attorney fees.

I hereby authorize and assign all payments, insurance or Medicare benefits for medical services and/or procedures rendered to the patient, directly to Sunshine Spine & Pain. I hereby authorize Sunshine Spine & Pain to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance company or Medicare.

If my insurance company requires referrals/authorizations, it is my responsibility to obtain such and if not, then I will be responsible for any unpaid balance.

By signing this agreement, I acknowledge that I have carefully read, understand and agree to the above terms and conditions. I also understand that is mandatory to tell Sunshine Spine & Pain if another party is responsible for paying for my treatment. Section 1128B of Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

Patient Signature ______________________________ Date ____________________

NO SHOW POLICY OF SUNSHINE SPINE & PAIN, PA:

There is a 24 hour notice required when canceling or rescheduling an appointment. Otherwise, there will be a $50.00 fee charged for missed office visits and for procedures.

Patient Signature ______________________________ Date ____________________

NOTICE OF PRIVACY PRACTICES RECEIPT

I acknowledge that I have received a copy of Sunshine Spine & Pain Notice of Privacy Practices.

Print Name ____

Signed __________________________________ Date ______________________