



*RICHMOND SPINE
INTERVENTIONS
and PAIN CENTER*

Specializing in Spinal Injection Techniques

Date: _____

I have informed the staff at Richmond Spine Interventions and Pain Center that my insurance coverage is as follows:

Primary Coverage: _____

Secondary Coverage: _____

According to my request, they will bill as listed above. I agree that if for some reason either of the above insurances refuse to make the required payment, I will be responsible for the balance left on my account.

Signature: _____

Relationship to Patient: _____
(If someone other than patient)

Witness: _____

Non-Par Clause:

I have been informed by the staff at Richmond Spine Interventions and Pain that they do not participate with _____, my insurance carrier; I have been informed that if I am seen, I will be held responsible for the charges incurred. I understand that I am seeking services that will not be covered by my insurance carrier. I am waiving the right to use my insurance and will be totally responsible for the balance on my account.

Signature: _____

Relationship to Patient: _____
(If someone other than patient)

Witness: _____

14404 Sommerville Court Midlothian, Virginia 23113
Phone: (804) 378-1800 Fax: (804) 378-5400

www.RichmondSpinePain.com