



*RICHMOND SPINE
INTERVENTIONS
and PAIN CENTER*

Specializing in Spinal Injection Techniques

Release Of Medical Information For Billing Purposes

I hereby authorize The Richmond Spine Interventions and Pain Center 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. Although medical information is confidential, many carriers require medical documentation prior to payment for services. I understand that only information pertaining to obtaining payment for my care will be released. I agree that a copy of this release maybe 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. I have read and agree to these terms.

Patient or Responsible
Party's Signature _____

Date _____

Payment For Medical Services

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 balances of bills not paid in accordance with the benefits of my current insurance policy. If I am unable to make payment in full for my medical treatment within 30 days, I agree to call the business office and make payment arrangements.

I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy, to be paid directly to The Richmond Spine Interventions and Pain Center or designates for services rendered.

I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's offices 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 The Richmond Spine Interventions and Pain Center to bill, in the event of non-payment for whatever reason in accordance with the benefits of my current insurance policy, I will pay immediately. It is further agreed that in the event I fail to pay upon demand, should my account be referred to an outside collection agency and or attorney, I accept full responsibility to pay all collection cost not to exceed 30% and interest of 1.5% per month not to exceed 18% per annum and reasonable court cost.

Patient or Responsible
Party's Signature _____

Date _____

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www.RichmondSpinePain.com