Parkway Brain and Spine

Signature for Consents and Authorization/Assignment of Benefits and Financial Agreement

Receipt of Privacy Notice:

I acknowledge that I have been given or have refused to take a copy of the Patients Notice of Privacy for Parkway Brain and Spine.

Consent for Treatment

I authorize Parkway Brain and Spine through it designated personnel, to perform an evaluation and treatment procedures, as necessary, on myself or the above named patient, if different than myself.

Authorization/ Assignment of Benefits and Financial Agreement

I _____ hereby authorize benefits to be assigned to Parkway Brain and Spine ("Provider"), for healthcare services to me by Provider. I hereby certify that the insurance information that I have provided Provider is true and accurate as of the date of service and that I am responsible for keeping it up today at all times. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I am responsible for payment of any and all amounts not paid by my insurance company due upon receipt of invoice or statement from provider, including for any services which my insurance company has determined not to be covered by my policy.

I hereby authorize Provider to submit claims on my behalf to the insurance company listed on the copy of the current insurance cared I have provided Provider. I assign exclusive and irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity in an amount or recovery not to exceed the extent of my bill for services provided by Provider, including exclusive and irrevocable right to receive payment for such services, make demand in my name for payment and prosecute and receive penalties, interest, court costs and other legally compensable amounts owed by an insurance company or other person or entity. I further authorize Provider to request and receive, on my behalf, from any insurance company or health care plan, any and all information and documents pertaining to my policy/plan, including a copy of the same and any information or supporting documentation concerning the handling, calculation, processing, or payment or claims as such documents are required by law or regulation to be presented to me. In addition, I agree to cooperate and provide information as needed and appear as needed to assist in the prosecution of such claims for benefits upon request by Provider.

I hereby irrevocably designate, authorize and appoint Provider as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered by Provider. This power of attorney shall automatically terminate, without formal action being taken, as soon as Provider has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to me. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

I hereby instruct and direct my insurance company to pay Provider directly for medical services and care provided by Provider, and to provide to Provider any and all relevant information and documentation in connection with such payments and claims for payment. I understand that I have the right and authority to direct were payment for services rendered is sent. if my current policy prohibits direct payment to the provider of services, I instruct that the insurer make out the check to me and mail payment directly to Provider 13 Western Maryland Parkway, Suite 106, Hagerstown, MD 21740, for the professional or medical expense benefits otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered by Provider. Upon receipt of said check, I authorize Provider to endorse such checks for deposit only, and deposit and apply all the proceeds toward payment on my account.

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this agreement of benefits.

If I am a Medicare or Medigap Benefit Participant I hereby authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or Carriers and/or Medigap insurance carrier, any information needed for this or related Medicare claim. I request Parkway Brain and Spine bill claims directly to Medicare and/or Medigap and for payments to be received directly by Parkway Brain and Spine. Medigap patients may receive the following message on their Explanation of Benefits: "Because you are assigned MEDIGAP benefits, information regarding your claim will be sent to your private insurer within 30 days." Section 4801 of the Omnibus Budget Reconciliation Act of 1987 provides an additional participation incentive for participating physicians by providing payment directly for assigned Medigap benefits.

I agree and understand that Parkway Brain and Spine will charge and bill me directly for Administrative fees for miscellaneous services, including but not limited to, preauthorization for prescriptions and /or imaging, insurance "Peer-to-Peer", Chlorhexidine preparation, medical record preparation, disability, motor vehicle and family medical leave forms, telephone consultations services for prescriptions and evaluation and management services.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize provider to be my personal representative, which allows Provider to: (1) submit any and all appeals if and when my insurance company denies my benefits to which I am entitled, (2) submit any and all requests for benefit information form my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of Provider's billed charges, due upon receipt of invoice or statement from Provider, of any an all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, I agree to pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any fines levied against my insurance company will be paid to Provider for acting as my personal representative.

Worker's Compensation:

- Worker's Compensation patients are required to provide claim number and claim adjuster information prior to their first visit. Patient appointments may be delayed without this information.
- Worker's Compensation cases are not to be filed through the patient's insurance company. If an attempt to file a claim through the personal insurance company is made, the patient will be held responsible for all charges.
- The office will obtain any approvals from worker's compensation for any treatments/procedures after the initial visit.
- Worker's compensation patient must provide their date of injury, name of worker's compensation company, claim number, name of claim adjuster/case manager, along with the contact information for their case manager. Failure to provide any or all of this information may delay being seen by a provider.

I acknowledge that I have read an understand the above statements:

Patient/Guarantor Signature: _____ Date: _____

Witness: _____ Date: _____