Maryland Brain, Spine & Pain

PATIENT NAME: _____DATE OF BIRTH: _____

CONSENT FOR ASSIGNMENT OF BENEFITS

I authorize this practice to apply for benefits from _____ (primary insurance carrier) and _____ (secondary insurance carrier) and further authorize payment directly to MARYLAND BRAIN SPINE, and PAIN for services rendered by the physician in this practice. **If you are a self pay individual (meaning you have no insurance), please let us know immediately so that special arrangements can be made with our office**. Medicare Only: I request that payment of authorized Medigap benefits be made on my behalf to MARYLAND BRAIN, SPINE & PAIN for any services furnished to me by physicians. In this practice I authorize any holder of medical information about me to release to_____ (Medigap insurer) any information needed to determine those benefits or benefits payable for related services.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of medical information required by my insurance carrier (or, in the case of Medicare Part B benefits, to the Social Security Administration and the Health Care Financing Administration) or its designated review agent, or (if applicable) my employer's worker's compensation insurance carrier in order to determine benefits to which I may be entitled, or to designated agents of this practice. This authorization may be revoked either by me or by the above carrier at any time in writing.

FINANCIAL AGREEMENT

I hereby assume financial responsibility for and agree to make payment in full to this practice for any and all charges for services or medical supplies received by me and/or any dependents not otherwise authorized or paid by my insurance carrier. Payment is to be made within 30 days as statements are presented with settlement in full, or payment arrangements to be made with the Billing Office. I certify that the financial information given is true, accurate, and complete to the best of my knowledge, and further authorize, MARYLAND BRAIN SPINE, and PAIN to investigate any and all financial information given concerning this or related claims. I further understand that this practice reserves the right to charge interest and/or pursue delinquent accounts via third party collection agencies or attorneys and that I am responsible for any fees and/or court costs incurred by this practice during the collections process.

I also agree to notify the practice of any changes in my billing address or telephone and/or my health insurance carrier information as they occur. This entire authorization is valid for all episodes of care rendered by all and any providers associated with the practice. I permit a copy of this authorization and agreement to be used in place of the original.

YEAR	SIGNATURE OF PATIENT	DATE OF SIGNATURE
2017		
2018		
2019		
2020		