Advanced Pain Management

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ASSIGNMENT OF BENEFITS

Private Insurance Authorization for Assignment of Benefits and Information Release

I, the undersigned, authorize payment of medical benefits to Advanced Pain Management (APM) for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize Advanced Pain Management (APM) to release to my insurance company, referring physician and other consultants on my case information concerning health care, advice, treatment or supplies provided to me. This information will be use for the purpose of evaluating and administering claims of benefits.

Date:_____Signed_____

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Advanced Pain Management (APM) for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Date:_____Signed_____

CERTIFICATION

Advanced Pain Management (APM) is pleased to offer you treatment for your injury or suffering. However, you are advised that according to most commercial insurance policies and generally accepted practice, treatment for work related chronic injuries must first be filed under Worker's Compensation. We will be happy to assist you in this process. Also, if this is a litigation case, our office needs to be informed before services are rendered,

*I _____ hereby certify that I **am/am not** seeking treatment for an illness or injury that resulted from an incident/accident at my place of work or from a motor vehicle accident.*

If applicable: MVA / Date of Incident: _____

If applicable: Attorney's Name: _____ Phone Number:_____

_____ _____ _____

Print Patient Name Date Signature

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of Advanced Pain Management (APM).

_____ _____ _____

Print Patient Name Date Signature

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