AUTHORIZATION AND ASSIGNMENT OF BENEFITS

It is our desire to assist our patients whenever possible. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain.

1. Waiting for insurance payment is a courtesy provided by Herring Spine & Rehab, Inc. We reserve the right to withdraw this courtesy at any time. It is your responsibility to supply this office with necessary forms to complete the billing. Direct assignment will be discontinued when you have finished corrective care and supportive health care program is recommended.

2. I authorize Herring Spine & Rehab, Inc. to release information deemed appropriate concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

3. **Herring Spine & Rehab, Inc. does not promise that an insurance company will pay.** In the event that the insurance disputes or rejects the claim it will be the patient's responsibility to pay the charge and pursue reimbursement from the insurance company

4. **All deductible amounts must be paid in advance for the first billing. I agree to stay current with my copays and/or percentage of responsibility (usually 20%).**

5. If you receive payment from your insurance carrier during the period which Herring Spine & Rehab, Inc. has accepted assignment of benefits, you are to bring the check to this office within one week of receipt and endorse it over to Herring Spine & Rehab, Inc. Failure to do this will result in collection and/or legal action. I give my permission to verify employment for collection and/or legal action.

6. If you discontinue your care for any reason other than discharge by the doctor you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company.

7. You agree, in order for us to service your account or to collect any amounts you may owe, Herring Spine & Rehab, Inc. or our assignee may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I agree that this office, or our assignee, may contact me as described above.

I have read the above and hereby agree by the provisions as specified above.

_____ _____

Signature of Patient/Responsible Party Patient Name

_____ _____

Relationship Date