

Pacific Coast Spine Institute and Pain Center

Huntington Beach Location
17742 Beach Blvd Suite 355
Huntington Beach, CA 92647

Laguna Beach Location
31852 Coast Hwy Suite 200
Laguna Beach, CA 92651

Phone (714) 847-3666
Fax (714) 847-7171

ASSIGNMENT OF BENEFITS

I, _____, hereby authorize _____
Name of Patient Name of Insurance Company

to pay directly to Pacific Coast Spine Institute and Pain Center all benefits, if any, for medical services and fees. If otherwise paid to me, I am financially responsible for all charges incurred. I also authorize the release of any medical information necessary to process claims.

Signature of Patient or Guarantor

Date

Please read each statement and initial to confirm you understand and agree:

___ If Dr. Rahbar should need to refer me to another medical facility or doctor for any reason, I hereby give authorization to release to that entity, any information that pertains to my case.

___ If my check is returned unpaid, my signature authorizes that a fee, as applicable by law, be charged to my account via electronic or paper draft.

___ Should an outpatient surgical procedure become necessary, I am aware that Pacific Coast Spine Institute and Pain center, and all of its personnel, do not honor Advanced Directives, and full resuscitation is attempted.

___ I consent to have my photograph taken for my medical record for visual identification purposes only.

___ If I fail to cancel a scheduled office visit more than 24 hours prior to the appointment I understand that I may be responsible for a \$25.00 cancellation fee. If I fail to cancel a scheduled procedure more than 72 hours prior to the appointment I understand that I may be responsible for a \$100.00 cancellation fee.

___ I have read the HIPAA statement indicating my rights as required by recent legislation (a copy of this statement can be given upon request).

Signature of Patient or Responsible Party

Date

Print Name of Patient or Responsible Party