Pacific Coast Spine Institute and Pain Center

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 the amount of the check, plus all fee's, as applicable by law, will be charged to my account.

____ 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