Center for Interventional

PAIN & SPINE

WILLOW GROVE, PA	NEWARK, DE	WILMINGTON, DE	BRYN MAWR, PA	EXTON, PA	WEST GROVE, PA
P: 215-957-1108	P: 302-266-7800	P: 302-477-1706	P: 610-525-8200	P: 610-280-0360	P: 610-280-0360
F: 215-443-9318	F: 302-266-7851	F: 302-477-1708	F: 610-525-8201	F: 610-280-0181	F: 610-280-0181

Name:_____ **Date of Birth:** _____

WORKMAN'S COMPENSATION OR **AUTO INSURANCE (LIABILITY)**

Insurance Carrier: _____

Address:_____

Po Box/ Street Address

_____

City *State* *Zip*

Claim/File Number_____

Date of Accident_____ State Accident Occurred_____

Injured Body Part _____

Claim Adjuster _____ Phone No._____

Employers Name: _____ Phone No. _____

Address: _____

ATTORNEY INFORMATION Attorney Name_____

Law Firm: _____

Address_____

Phone No. _____ Fax No _____

ASSIGNMENT AND AUTHORIZATION

I hereby transfer and assign to Center for Interventional Pain & Spine and affiliated business, funds out of any settlement or verdict by the Law Firm of: _____ in my legal case arising out of my accident with:

_____ to the extent of any and all bills for medical services rendered and/or not paid by

Name of company

Worker's comp, automobile, personal injury protection insurance, or any other insurance, and I hereby authorize the said law firm to make direct payments to Center for Interventional Pain & Spine of said funds.

_____ _____

Patient's Signature Date

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F: 215-443-9318	F: 302-266-7851	F: 302-477-1708	F: 610-525-8201	F: 610-280-0181	F: 610-280-0181

PROMISSORY AGREEMENT

PATIENT NAME: _____ DOB: _____

I _____ am aware that if my W/C or AUTO **(please circle one)** carrier,

_____ denies the claim for any of my office visits, or procedures, that I will be fully responsible for payment since I do not have secondary insurance or am not willing to provide the information of my secondary insurance carrier.

I understand that I may set up payment arrangements with Center for Interventional Pain & Spine for my balance, but the balance must be paid in full within six months from the date of my denied office visit or denied procedure. If no payment arrangement is made within 30 days from the date of the first statement the account will be sent directly to a collection agency.

I understand that this agreement is for Center for Interventional Pain & Spine and the bills for a facility fee, anesthesiology fee, and other fees are separate from this amount. I am aware that I will be responsible for those bills as well, and will receive them directly from those providers.

I fully understand that I am responsible for all charges in the event of non-payment by an insurance company and that payments not made as agreed in the above terms will result in the account to be referred to outside collection agencies. I agree to notify the Center for Interventional Pain & Spine in the event of change of address.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date