CONSENT

Form #1

AUTHORIZATION / ASSIGNMENT OF BENEFITS

General Consent for Medical Services

Once discussed with me in advance, I hereby authorize recommended treatment and or procedure(s) as determined by the physician(s) of Midwest Pain Institute.

Medicare Authorization

I request the payment of authorized Medicare benefits be made directly to Midwest Pain Institute, for any service rendered to me, including physician charges. I understand that I am responsible for any services not covered by Medicare and any applicable deductible or coinsurance amounts.

Assignment of Benefits

I hereby authorize, request and assign payment directly to Midwest Pain Institute covering this period of treatment and related past and future treatments, by all insurance carriers with whom I have coverage. This authorization also extends to any other benefits payable to me including settlements or judgments flowing from the incident(s) for which I am receiving treatment.

Payment Guarantee

All professional services rendered are charged to the patient or financially responsible party. As a courtesy to you, we will file all claims to your insurance company. All services rendered must be paid in full at the time of service, until your deductible has been met. If you have no deductible, or it has been met, you must pay all "co-pays" or percentages as dictated by your insurance carrier. If you have met your deductible with another provider, documentation must be provided. If you have no insurance, you must pay in full at the time of service, unless prior arrangements have been made.

Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 60 days, your will be responsible for the remaining charges and we will continue to assist you in resolving the balance.

I understand and agree that I am solely responsible for all charges to my account. I agree to pay all collection costs, returned check fees, attorney fees and court cost incurred by Midwest Pain Institute in the collection of all sums due.

Usual and Customary Rates

Out practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Authorization for Release of Information to the Insurance Company

I authorize the release of any medical information about me, to my insurance company(s) or the Health Care Financing Administration (HCFA) and its agents, needed to determine these benefits or benefits for related services.

Notice of Managed Care and Cancellation Policy

If in the event your insurance plan should require any form of care management, such as prior authorization or referral, it is your responsibility to notify us in advance; so we may assist you with those services.

Unless cancelled at least 24 hours (for office consultations) and 48 hours (for procedures) in advance, a fee will be assessed. (Not billable to any insurance carriers.) Cancellation fee for office consultations is $25.00 and $50.00 for procedures. Third and/or successive appointments cancelled without acceptable notice, will be charged double the rates listed above. Please help us serve you better by keeping scheduled appointments.

X ______________________________

Print Patient Name

X ______________________________ Date: ______________

Signature of Patient or Responsible Party