



RAPHA SPINE & NEURO CENTER

CONSENT TO TREAT, ASSIGNMENT OF INSURANCE BENEFITS, AND FINANCIAL RESPONSIBILITY AGREEMENT

1. CONSENT: The undersigned patient consents to x-ray examinations, lab examinations, physio-therapy, acupuncture, chiropractic, laser therapy and/or other health care treatments rendered under general and/or special instructions of the attending physician, consulting physician(s), their assistants, or designees—all who are in charge of the care and treatment of the patient.

2. HEALTH CARE SERVICES: The undersigned recognizes that the practice of chiropractic and other health care and treatment is not an exact science and acknowledges that no guarantees have been made about the results of such care and treatment, whether by Rapha Spine & Neuro Center physicians and consulting physicians or by their assistants or designees.

3. RELEASE OF INFORMATION: It is agreed that all records concerning the undersigned patient's treatment remain the property of Rapha Spine & Neuro Center, or any corporate successors or affiliates to which it may transfer ownership. The undersigned agrees that to the extent necessary to determine liability for payment and to obtain reimbursement, Rapha Spine & Neuro Center may disclose all or part of the patient's record to any person or entity which is or may be liable for all or any portion of charges due to Rapha Spine & Neuro Center and/or successors or affiliates. Such entities may include, but are not limited to, insurance companies, worker's compensation carriers, health care service plans, welfare funds, or the patient's employer. Rapha Spine & Neuro Center will obtain written authorization to otherwise release information concerning the patient, except in those circumstances in which Rapha Spine & Neuro Center is permitted or required by law to release such information.

4. ASSIGNMENT OF INSURANCE BENEFITS: In the event that the undersigned patient is entitled to benefits arising out of any policy of insurance insuring the patient, the patient, the undersigned, who is either the patient or the party responsible for the patient, specifically assigns such benefits to Rapha Spine & Neuro Center or, where applicable, its affiliates or successors, for application to the patient's bill. The undersigned also authorizes and directs that the applicable insurance company make all due insurance payments directly payable to Rapha Spine & Neuro Center.

For patients covered by insurance, most policies do not cover 100% of treatment cost. Even when they do, there is a very long delay between treatment and payment. As a result, you will be asked to pay your deductible and/or portion of your charges for each day or week you receive treatment. Rapha Spine & Neuro Center staff will estimate as best they can your probable coverage, but until your insurance company actually pays your bills, staff figures are only estimates. If the estimate is insufficient, you must pay the amount not covered by your insurance. We will assist you in dealing with your insurance company, but you are responsible for any payments due that your insurance does not cover, no matter what the reason. If we have not received payment from your insurance company within 60 days of service, you will be responsible for payment in full. If you are here due to an auto accident or worker's compensation, please see our insurance representative for full details on your coverage. In addition, if you have any questions that remain unanswered before or after treatment, please ask our insurance representative.

5. AGREEMENT TO PAY FOR SERVICES: I, the undersigned, accept responsibility for payment of services rendered as treatment of the patient named below. I understand and accept that I must pay interest, compounded monthly at 1.5%, on outstanding balances past due thirty days. Moreover, if payment is not made and additional collections efforts are required, I hereby agree to pay all bills rendered for said patient together with all collection costs, interest fees, court costs, and reasonable attorney's fees of one-third of the balance due. I understand that all bills are payable and become due upon presentation.

6. FAILURE TO NOTIFY OF INSURANCE COVERAGE/SERVICE OUTSIDE OF INSURANCE PLAN: If at the time of the patient's treatment, Rapha Spine & Neuro Center is not advised that the patient is or may be covered by insurance, the patient agrees to make payment in full for all services rendered, regardless of whether the patient was actually covered by insurance at the time of treatment. In addition, if the patient receives services not covered by the patient's insurance plan, the patient agrees to make payment in full for all such services rendered. All payments for any balance owed are due in 30 days.

The undersigned certifies that he/she has read and understands the forgoing, and is the patient or is duly authorized by the patient as the patient's attorney-in-fact to execute the above and accept its terms.

X _____
Patient Signature Date

Print Name of Patient

Signature of Other Responsible Party Date

Print/type Name of Other Responsible Party

Social Security # of Other Responsible Party

Witness

Witness