CENTRAL VALLEY PAIN MANAGEMENT

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR TREATMENT

I authorize Central Valley Pain Management to render medical treatment and services to _____ *(print patient name)* and agree, irrevocably, whether signing as the patient or designated representative of the patient, that in consideration of the services to be rendered to the patient, that I hereby individually obligate myself to pay the account in accordance with the regular rates and terms as set forth by the provider. I hereby give authorization for payment of insurance benefits directly to Central Valley Pain Management & Wellness Clinic and any assisting providers for services rendered. As required by law, you are hereby notified that a negative credit report may be submitted to a credit reporting agency if you fail to fulfill the terms of your credit obligations. Should the account be referred to an attorney or collection agency for collection, the undersigned agrees to pay actual attorney's fees and collection expenses. It is agreed that payments will not be delayed or withheld because of any insurance coverage or pending of claims thereon and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. A copy of this assignment is as valid as the original.

CASH PAY /NO INSURANCE:

You will need to pay for every office visit, or service (s) at the time of appointment. Financial arrangements will not be made.

PRIVATE/HMO/MEDICARE/MEDI-CAL INSURANCE:

We require a copy of your insurance card. It is your responsibility to keep us updated if your insurance plan changes or terms. At each appointment, you are required to pay your co-pay, co-insurance, share of cost and/or payment on your account. Billing your insurance is done as a courtesy and we are REQUIRED by the insurance contracts to collect your co-payment at the time of your appointment. Financial arrangements will not be made for co-payments. If you do not have your co-pay/co-insurance, your appointment may be rescheduled. However, if you are seen without paying your co-pay/co-insurance, please be advised a billing fee will be charged. If you receive a bill from our office and cannot pay it in full, you must call and make arrangements with the billing department.

NO-SHOWS/CANCELLATIONS WITHOUT 24HR NOTICE:

We require a 24-hr. notice to cancel an appointment. If a notice is not given, or an appointment is no-showed, you will be required to pay a fee of $50. NO EXCEPTIONS

Patient Signature _____ **Date** _____

Designated Agent Signature _____**Date**_____

Designated agent's relationship to the patient: _____