Name:________________________________Date:________________________________

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. Please be advised that we will submit to your primary and secondary insurance. Any remaining balance after receipt of explanation of benefits from your primary/or secondary insurance carrier will be billed to you.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Subscriber:____

Relationship: ___ Self ___ Spouse ___ Parent ___ Other

Primary Insurance Policy:____

Secondary Insurance Policy:____

I request that payment of authorized Medicare/other insurance company benefits be made either to me on my behalf or to IPM, Interventional Pain Management Associates for any services furnished to me by that third party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers and information needed for this or a related Medicare claim/other Insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

____

Signature of Patient or Responsible Party Date

________(Please initial) I have been offered a copy and an explanation of the Notice of Privacy Practices (HIPAA)