Assignment of Benefits

I certify that the information given by me is correct. I hereby authorize payments directly to Consultants in Pain Management of the insurance benefits otherwise payable to me. I understand I am financially responsible to Consultants in Pain Management for any charges not covered by this authorization.

Date:_____ Signed:_____

Medicare Patients

I hereby authorize Medicare to furnish Consultants in Pain Management any information regarding my Medicare claims under "Title XVIII" of the Social Security Act. I also request payment of authorized benefits be made on my behalf to Consultants in Pain Management for any services furnished to me. I Authorize any holder of medical information about me to release the MEDIGAP INSURER on the opposite page any information needed to determine these benefits or the benefits payable for related services.

Date:_____ Signed:_____

Financial Responsibility Agreement

FOR AND IN CONSIDERATION of health care and health care related services and treatment rendered or to be rendered to the patient identified below, and the extension of credit to the patient according to the Financial Policies of Consultants in Pain Management, PC I/WE, promise and agree to pay in full to Consultants in Pain Management upon demand, all charges incurred on the account of the patient hospitalization or treatment (including out-patient or clinic services) at our offices, hospitals, of other locations.

Payments received from insurance of other third-party payers for services and treatments rendered, be applied to the patient account and the balance, if any, shall be and remain my/our responsibility. I/WE represent that I/WE have read this Financial Agreement, understand its terms and conditions, and sign the agreement voluntarily for the purposes stated in this agreement.

Date:_____ Signed:_____

I hereby authorize any personal at Consultants in Pain Management to take photographs necessary to document my physical condition. The photograph can/will be used for educational and of therapeutic purposes only.

Date:_____ Signed:_____