

# COMPREHENSIVE PAIN MANAGEMENT, P.C.

## PATIENT FINANCIAL RESPONSIBILITY FORM AND LIMITED POWER OF ATTORNEY

**Assignment of Insurance Benefits Up to Amount of Medical Services:** In consideration of medical and other healthcare services to be rendered (the "Medical Services") to me (or to the patient, if I am the guarantor thereof) by Comprehensive Pain Management, P.C. or any of its affiliates, entities it controls, is controlled by, or under common control with (collectively, "CPM"), I, the undersigned patient (or guarantor of the patient signing below) hereby assign and transfer, and authorize to be assigned and transferred, to CPM any benefits payable to or for patient's benefit under any health, medical, hospitalization, or other insurance coverage for payment of the Medical Services. This assignment of benefits is irrevocable and extends to the total amount owed by me to CPM from time to time. I hereby certify that the insurance and other information that I have provided CPM is true and accurate as of the date(s) the Medical Services are to be performed and that I am responsible for keeping such information updated. I am fully aware that having health insurance does not absolve me (and the patient, if I am the guarantor) of my responsibility to ensure that the medical bills for the Medical Service are paid in full. I also understand that my Insurance Company (as such term is defined below) might not pay 100% of the amount billed by CPM for the Medical Services. **I AGREE TO PAY FOR ANY AND ALL AMOUNTS CHARGED BY CPM FOR MEDICAL SERVICES WHICH CPM HAS NOT RECEIVED PAYMENT FOR FROM MY INSURANCE COMPANY WITHIN FORTY-FIVE (45) DAYS OF CPM'S PROVISION OF THE MEDICAL SERVICES.** Insurance companies reimburse on a fee schedule, which may bear no relationship to the current standard and cost of care in this area. I hereby agree to cooperate with CPM to obtain necessary authorizations from my Insurance Company or other insurers.

**Authorization to Submit Insurance Claims:** I hereby authorize CPM to submit claims, on my behalf to my insurance company (the "Insurance Company (s)") listed on the copy of the current insurance card(s) I have provided CPM, which I represent I have provided to CPM "in good faith" and which I represent provides current medical coverage for the contemplated Medical Services. I fully agree and understand that the submission of a claim does not absolve me (or the patient, if I am the guarantor) of my responsibility to ensure the claim is paid in full. If benefits cannot be determined, benefits are denied, and/or when there is any doubt of coverage, I hereby acknowledge that full payment for the Medical Services is due at the time of my appointment. CPM's preferred method of payment is cash; however we will accept personal checks, debit cards, MasterCard and VISA. There is a \$1.50 additional fee for credit or debit card payment.

**Limited Attorney-in Fact to Obtain Payment and Patient Information:** I hereby irrevocably designate, authorize and appoint CPM as my true and lawful personal representative and attorney-in-fact for the limited purpose of performing all acts, deeds, matters and things, as I might or could do in my own proper person, if personally present, related to (a) my relationship with my Insurance Company (s), (b) obtaining payment from my Insurance Company (s) with regard to the Medical Services, and (c) obtaining information related to the Medical Services and my benefits from my Insurance Company (s). The powers granted to CPM herein include, but are not limited to, the power to (i) receive any and all payments for the Medical Services from my Insurance Company (s) or other third parties, (ii) submit and receive any and all requests for benefits information from my Insurance Company (s), (iii) request, receive, and review any and all applicable plan documents or other information from my Insurance Company (s) concerning me, (iv) pursue all remedies as to claims as to the Medical Services with or against my Insurance Company (s), including, but not limited to, formal complaints, appeals, administrative reviews or litigation to any State or Federal agency, insurance board or insurance company that has jurisdiction over benefits that are or may be available to pay for all or part of the Medical Services, and (v) request and receive any and all information from my Insurance Company that I am entitled. This power of attorney shall automatically terminate, without formation action being taken, as soon as CPM has received payment in full for the Medical Services. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

**ERISA Authorization:** I hereby authorize and direct my Insurance Company (s) to assign and transfer any applicable ERISA plan benefits and right to CPM including the right to receive any applicable plan documents and/or remedies, and to pursue appeals, administrative reviews or litigation on my behalf.

**Direct Payment Authorizaion: I HEREBY INSTRUCT AND DIRECT MY INSURANCE COMPANY(S) TO PAY CPM DIRECTLY. I UNDERSTAND THAT I HAVE THE RIGHT AND AUTHORITY TO DIRECT WHERE PAYMENT FOR SERVICES RENDERED IS SENT.** If my current insurance policies with my Insurance Company (s) prohibit direct payment to the provider of services, I (under my rights per State and Federal regulations) hereby instruct and direct my Insurance Company (s) to provide supporting documentation evidencing the existence of such non-assign ability clause to myself and to CPM. Upon receipt by CPM of the nonassignability documentation, I instruct the Insurance Company (s) to make out the check to me (or the patient, if I am the guarantor) and mail such check directly to CPM at 3870 Medical Park Drive, Austell, Georgia 30106 as payment towards the total charges for the Medical Services rendered. In the event my Insurance Company does not mail the check (made out to me) directly to CPM, I hereby agree to mail such check to CPM at the address above as soon as I receive it. I agree and understand that any funds I receive from my Insurance Company (s) due me (or due the

patient, if I am the guarantor) for the Medical Services will be immediately signed over by me and sent directly to CPM.

**Check Deposit Authority:** Whenever my Insurance Company (s) might send a check directly to me for the Medical Services provided by CPM, if I deposit such a check into an account other than CPM, I agree to send CPM a payment for the equivalent amount. If I receive from any insurance company, Medicare or Medicaid, and Explanation of Benefits (EOB), I agree to send a copy of such immediately to CPM. Upon receipt by CPM of any and all checks made payable to me or patient, I authorize CPM to receive such check, endorse it for deposit only, and to deposit it and to apply all the proceeds toward payment on my account for the Medical Services.

**Copays:** I hereby agree to, at the time the Medical Services are rendered, pay all copays, coinsurance, deductibles, and all other procedures, treatments or services not covered by my Insurance Company.

**Attorneys Fees:** If my account with CPM is referred to an attorney or outside agency for collection, I agree to pay reasonable attorney fees and collection expenses. All delinquent accounts bear interest at the maximum legal rate. I understand and agree that if my account is delinquent, I may be charged a service fee.

**Consent to Credit Report:** I agree to allow CPM to obtain my credit report from a credit reporting agency chosen by CPM. I hereby authorize such credit reporting agency and CPM to obtain information regarding my employment, my accounts, and outstanding credit accounts. I hereby authorize such credit reporting agency to release a copy of my credit application.

**Release of Medical Record to Obtain Coverage:** I authorize the release of any medical or other information reasonably necessary to determine benefits available or benefits payable by my Insurance Company (s) or for the purposes of satisfying charges billed by CPM for Medical Services to my Insurance Company (s) or other entities, if requested. I hereby release and forever discharge CPM and its respective employees, directors, officers, shareholders, agents, assigns and legal representatives from any and all obligations, claims, liabilities, damages, debt, liens, and deficiencies arising out of or in connection with CPM's use or disclosure of my health information.

**Miscellaneous:** A photocopy of this document shall be considered as effective and valid as the original. For checks returned to CPM for non-sufficient funds by your bank, CPM will charge a \$25.00 fee per returned check.

Patient/Guarantor

Date

Print Name of Patient/Guarantor