Name: ______________________________ Date of Birth: ____/____/____

PAYMENT POLICY

GROUP/INDIVIDUAL INSURANCE:

Your insurance is an agreement between you and your insurance company, not between your insurance company and our Clinic. We offer a complimentary benefits check to verify coverage; however, the benefits quoted to us by your insurance company is not a guarantee of payment.

As a courtesy to you, we will complete and file any necessary insurance forms at no additional charge. It is to be understood and agreed that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, co-insurances, deductibles or co-pays. If your insurance does not respond within 60 days, or if you suspend or terminate care, any fees for services will be due immediately.

ASSIGNMENT OF BENEFITS:

I, ______________________________, authorize and direct my insurer or payor to pay directly to Dr. ML Woodruff, DC with Spinal Centers, Inc. any or all benefits, that would otherwise be payable to me (or the patient, if signed by a responsible party), up to the amount of my bill, accruing to me in connection with my treatment by the doctor at his clinic.

AUTHORIZATION TO ASSIGN INSURANCE BENEFITS:

I request that payment of authorized benefits under any private or government insurance program that covers me, including Medicare and Medicaid, be made on my behalf directly to Spinal Centers, Inc. I understand by signing this form I am authorizing Spinal Centers, Inc. to receive payments directly from any private or government insurance program that covers me for as long as I seek care or until I withdraw my consent in writing. In the event that payments are made to the doctor and me as joint payees, I agree to cooperate with his office to ensure that he receives all amounts due to him and Spinal Centers, Inc. I understand that I am liable to Spinal Centers, Inc. for all related charges, whether or not covered by insurance.

STATEMENT OF FINANCIAL RESPONSIBILITY:

I acknowledge that I am legally responsible for all charges for the services provided to me by Spinal Centers, Inc. to the extent those charges are not covered or paid by my insurance carrier/health plan or by another payment source such as Medicare or Medicaid. I understand that my insurance carrier/health plan may not approve or pay for the medical services provided by Spinal Centers, Inc. and understand that I am personally responsible for payment of all charges not paid in full, co-payments, policy deductibles, and co-insurance except where my liability is limited by contract or State or Federal law. In the event of non-payment, I understand non-payment will be reported to credit reporting agencies and agree to pay all reasonable costs of collection including attorney's fees. Spinal Centers, Inc. is authorized to access credit bureau files and reports now and in the future for collection purposes. In the event that Spinal Centers, Inc. elects to bring an appeal, lawsuit or petition for arbitration against the insurance carrier, I hereby assign to them my rights, title and interest under any insurance policy under which I am entitled to proceed for benefits, if allowable under the State or Federal law.

NON-COVERED AND/OR NON-MEDICALLY NECESSARY SERVICES:

I acknowledge that I am legally responsible for all charges associated with the provision of non-covered and/or non-medically necessary services. I understand Spinal Centers, Inc. is not responsible for insuring that I understand which services are not covered or not considered medically necessary by my insurance carrier/health plan except where required by federal law. I understand it is my responsibility to review my insurance plan benefits and accept responsibility for payment should I choose to proceed with care.

This assignment shall allow an attorney of their choosing to bring suit or submit to arbitration their claim of any unpaid or underpaid bills for treatment rendered by Spinal Centers, Inc.

I hereby certify that I understand and agree to the insurance policies and assignment of benefits set forth as above by Spinal Centers, Inc.

Patient's signature or authorized person acting on patient's behalf.

Signature______________________________

Print Name:______________________________ Date:__________

Spinal Centers, Inc.

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Pensacola FL 32526
850-434-8880

24 E Nine Mile Rd
Pensacola FL 3251
850-479-1333