



Authorization for Payment

I understand that fees for professional services rendered at Integrated Spine Care are determined from national and regional benchmarks. Fees are available for review and patients are encouraged to understand fees. Insurance companies often make arbitrary determinations of “usual and customary” fees that are consistently below prevailing fees for this and other similar practices. I understand that I may be responsible for the entire fee whether or not it is determined to exceed the “usual and customary” fee depending on my insurance plan. Accounts are due at the time services are rendered.

I understand that my insurance benefits may not pay all or even ANY of the amount due for the care provided. I understand that it is my responsibility to determine the benefits provided by my insurance. I understand that my care provider at Integrated Spine Care SC, may or may not be a preferred “in-network” provider for my insurance plan. It is my responsibility to make this determination. I understand that I will be responsible for any and all charges not covered by my insurance plan as permitted by law. These charges may include but are not limited to deductibles, co-insurance payments, and amounts that exceed “usual and customary” determinations by insurance plans. I understand that I may be referred for additional testing or care (ex. MRI, CT, x-rays, injections or therapy) by providers that may or may not be in my insurance provider network. I understand it is my responsibility to determine my insurance benefits for this care. Integrated Spine Care is not responsible to make this determination or use providers in my insurance plan network.

Worker’s Compensation: If I am being treated for a work related injury, Integrated Spine Care, SC will bill my employer, or my worker’s compensation carrier. If my worker’s compensation claim is contested or denied, Integrated Spine Care SC is authorized to bill my private insurance carrier. I am responsible for payment for services rendered while disputes are being resolved. Accounts are due at the time services are rendered.

I authorize payment to Integrated Spine Care, SC and my doctor. A photocopy, facsimile, or electronic image of this authorization shall be as valid as the original.

I have read and agree to the above statements. No alterations of this agreement are permitted.

Patient Name: _____

Date: _____

Signature of Patient: _____

Or signature of other person legally authorized to consent: _____