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FINANCIAL AGREEMENT

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Please remember that insurance is considered a method to reimburse the patient for fees put to the doctor and it is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection an/or suit, Oregon Spine and Disc shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

Patient Signature

Date

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Oregon Spine and Disc all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy an/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance polices and/or employee healthcare plan, any claim, chose in action, or other right I may have to such insurance and/or employee healthcare benefits coverage under any applicable insurance policies and/or employee healthcare plan with respect to any medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation. I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee healthcare plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee healthcare plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature (Insured or Guardian) _____ Date _____

Print Name _____