Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible for any charges not covered by my insurance plan. It is my responsibility to know my plan benefits, in some cases exact benefits cannot be determined until the insurance has received the claim; at which time I will be billed the remainder of the charges. I understand that I am responsible for the entire balance of the bill if the submitted claim or any parts of it are denied for payment. By signing this form, I am accepting financial responsibility as explained above for all payment of medical services received. I authorize the disclosure of my medical information and medications to other physicians involved in my care.

Print Name: _____

Signature: _____ Date _____

(Signature) by signing I am acknowledging that all the information given is true and accurate to the best of my knowledge

Pro Pain LLC