SPINE & PAIN CENTERS
OF NEW JERSEY & NEW YORK

PAYMENT AUTHORIZATION FORM

Patient Name:_____ **DOB**_____/_____/_____

For and in consideration of services rendered, I agree to make payment to Spine and Pain Centers when billed for any and all charges not covered by valid insurance benefits. I authorize payment directly to Spine and Pain Centers for health insurance benefits payable to me under terms of my policy but not to exceed the balance due for services performed during this period of treatment. Spine and Pain Centers may seek, release and verify all or part of my medical and/or financial records to any person, corporation or government agency which is or maybe liable under a statute, regulation or contract to Spine and Pain Centers, myself, a family member or my employer for all or part of the Spine and Pain Centers charge.

If any of the following changes: patient's address, patient's phone number, patient's insurance information or any other information necessary for Spine and Pain Centers process your medical bill, the patient must inform Spine and Pain Centers promptly.

In the event the provider's charges are outstanding, I hereby authorize the provider to file such claim and/or action on my behalf so that the provider may receive payment of their charges. I understand that, if the provider does not receive payment from the insurer, I remain personally responsible for payment of the provider's charges.

Medicare – Authorization to release information and payment request:
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to this or a related Medicare claim. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for physician's services to the physician or organization furnishing the services or authorize such payment or organization to submit a claim to Medicare for payment.

Please check the appropriate box: (MEDICARE CERTIFICATION)

I am entitled to benefits under Medicare Hospital Insurance, Part A.

☐YES ☐NO

I am entitled to benefits under Medicare Hospital Insurance, Part B.

☐YES ☐NO

_____ _____

Date Signature