INTEGRITY PAIN MANAGEMENT CENTER

KERRY C. LATCH, M.D. / CHRISTIAN SAMUELSON, M.D.

☐ ***ASSIGNMENT OF BENEFITS:*** I hereby authorize payment directly to INTEGRITY PAIN MANAGEMENT CENTER of any and all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to INTEGRITY PAIN MANAGEMENT CENTER for charges not covered by this assignment. I understand that should I bill my managed care insurance directly, I am not entitled to any further discounts.

☐ ***RELEASE OF INFORMATION:*** I hereby authorize INTEGRITY PAIN MANAGEMENT CENTER to furnish my insurance company or companies, or their representatives with any and all information that may be contained in their medical records.

☐ ***LIFETIME MEDICARE B SIGNATURE AUTHORIZATION:*** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of INTEGRITY PAIN MANAGEMENT CENTER any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used on place of the original, and request payment of medical benefits be made to the holder of the assignment of my behalf. I understand that I am responsible for any health deductibles and coinsurance.

☐ ***LIABILITY / INSURANCE WAIVER:*** I hereby state that I wish INTEGRITY PAIN MANAGEMENT CENTER to submit my claim for medical services to _____for services rendered for the accident date of: _____. I am not filing this claim with any other liability insurance and will not be making any claim to any other general liability insurance or company. I also understand that if I do submit this to any other general liability insurance or company that _____ will have to be refunded immediately and the total amount originally charged for the services rendered will become due and payable by me. Filing your liability insurance does not constitute and assignment. If this is a legal case, we do not accept assignment pending the outcome of your case. You are responsible for your bill in its entirety.

☐ ***LIABILITY / ATTORNEY - MEDICAL RECORDS RELEASE:*** I authorize INTEGRITY PAIN MANAGEMENT CENTER to release my medical records to my attorney: (name) _____
address: _____ phone #: _____

☐ ***WORKER'S COMPENSATION:*** This authorizes my physician to furnish written reports and communicate orally with any representative, attorney for, or investigator from my Worker's Compensation carrier _____ regarding my examination, diagnosis, treatment, and prognosis concerning injuries sustained as a result of an accident occurring on the _____ day of _____, 19____.

☐ ***IF PATIENT IS UNDER 18:*** I hereby give my permission for _____ to be treated by Dr. _____.
Patient Name

_____ _____ _____
Signature / Telephone Verification Witness Date

I have reviewed the **Notice of Privacy Practices** from **Integrity Pain Management Center** concerning how the use or disclosure of **Protected Health Information** will be handled by the practice. I give **Integrity Pain Management Center** consent to use or disclose my **Protected Health Information** for purposes of treatment, payment, and restrictions and to revoke this consent.

THESE AUTHORIZATIONS MUST BE SIGNED IN ORDER TO EXPEDITE THE FILING OF YOUR INSURANCE CLAIM

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

Name of Custodial Parent or Legal Guardian (Please Print): _____

Parent/Guardian's Signature: _____ Date: _____

Witness: _____ Date: _____