INTEGRITY PAIN MANAGEMENT

Kerry C. Latch, M.D./ Christian Samuelson, M.D.

PATIENT SERVICE AGREEMENT

Guarantor Statement:

I hereby agree to assume financial responsibility for any and all reasonable charges in accordance with service provided me or my dependent(s) at this facility.

In the event my account becomes delinquent, I will assume total responsibility for any reasonable collection expenses or attorney's fee associated with the collection effort.

Assignment of Benefits:

I hereby agree to the authorization and assignment for payment to be made to the facility named above, by any and all insurance claims regarding all professional services rendered. In the event that my insurance company pays me directly, I will upon receipt, remit the entire amount to the facility named above. It is understood that my account will not be considered closed until all remaining balances are paid, regardless of the amount of percent of insurance coverage.

Disclosure of Information:

I hereby authorized and consent to the disclosure or release of any all medical records and films relative to my condition, care or treatment either by or to the facility named above, my referring physician and all other physicians participating in my care.

I agree that the conditions set forth in the above agreements have been explained to me and that I agree to and understand its contents.

_____ _____

Signature Date

_____ _____

Witness Date