SPINAL DIAGNOSTICS

Robert D. Heros, M.D.*Jason G. Anderson, D.O.* Tyler Huntington, PA-C

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

All other insurance companies and/or third party payers: I HEREBY AUTHORIZE Spinal Diagnostics Robert Heros, M.D., Jason G Anderson, D.O., Tyler Huntington, PA-C, and/or any of their representatives to submit a claim to my insurance carrier or its intermediaries for all services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment directly to the physician(s) rendering the service. I authorize the release of any and all medical information to my insurance carrier or it intermediaries for services rendered.

Medicare: I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of Medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, or its intermediaries or carriers any and all information needed for this or a related Medicare claim. I authorize and request that payment be made directly to Spinal Diagnostics, or their representative.

Guarantee of Payment: I UNDERSTAND that filing a claim with my insurance company or other third party payor, under any circumstance, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Spinal Diagnostics (Dr. Heros, Dr. Anderson,Tyler Huntington) to me. I understand that it is ultimately my responsibility to verify my insurance benefits, eligibility and authorization requirements prior to any scheduled appointments. By signing this document I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to, claims filed for Worker's Compensation, automobile accidents and/or personal injuries. If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs even if there is a pending lawsuit. Payment must be made in full within 30 days of being billed unless prior arrangements have been made.

I AGREE that this authorization shall be valid until rescinded in writing or replaced on a later date.

_____ _____

*Patient's signature (parent or Guardian if patient is a minor) Date of Signature

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice

_____

*Patient's signature (parent or Guardian if patient is a minor)

_____ _____

*Please Print Name Date of Signature

If Personal Representative's signature(s) appears above, please describe the relationship to the patient:

_____

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