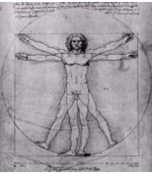

River North Pain Management Consultants, S.C.,
Axel Vargas, M.D.,
Regional Anesthesiology and Interventional Pain Management.
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AGREEMENTS AND AUTHORIZATIONS

On___________ Ms. / Mr. _______________________________is scheduled to have a consultation and/or a procedure, with one of our physicians at the Rivernorth Pain Management Consultants. I realize that the doctors at the Rivernorth Pain Management Consultants (RNPMC) are contracted with many insurance companies; however they may not be contracted with some. If any of our physicians is not contracted with your insurance company, it is likely that your co-insurance and/or deductible will be higher than if you were in-network, and it may also possibly that you may be responsible for any fees that your insurance carrier does not pay. Additionally, please be aware also that your insurance carrier might send payment directly to you, in which case you are advised to promptly forward such payment to our office for proper processing.

Authorization for Disclosure of Medical Information

I hereby authorize the physicians at Rivernorth Pain Management Consultants (RNPMC) to release to my insurance companies, employer insurance groups, health plans, Medicare, or any intermediaries, or physicians associated with Rivernorth Pain Management Consultants (RNPMC) and any billing or collection agents of Rivernorth Pain Management Consultants (RNPMC), any medical or financial records or other information concerning this treatment to obtain reimbursement on my behalf for the treatment and services provided to me by the physicians at Rivernorth Pain Management Consultants (RNPMC)

X____
(Patient/responsible party's signature) (Witness) (Date)

Assignment of Insurance Benefits/Payment Guarantee/Collection Fee

I hereby authorize payment to be made directly to any of the physicians at the Rivernorth Pain Management Consultants (RNPMC) for insurance benefits payable to me. I understand that I am financially responsible to the physicians at the Rivernorth Pain Management Consultants (RNPMC) for any covered or non-covered services, as defined by my insurer, which are not paid by my primary or secondary insurer. I also understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, a collection fee, not to exceed 25% of the overdue balance, may be added to the amount due and that I am financially responsible for the added collection fee and any reasonable attorneys' fees and other cost incurred for collection.

X____
(Patient/responsible party's signature) (Witness) (Date)

Notice and Acknowledgement

I acknowledge that I have received Rivernorth Pain Management Consultants (RNPMC) Privacy Notice.

X____
(Patient/responsible party's signature) (Witness) (Date)

Insurance company: ________________________Group# ______________________ID#_______________________________

Rev/110507 (AV)