EXODUS
PAIN CLINIC
INTERVENTIONAL SPINE & PAIN MEDICINE

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PATIENT FINANCIAL AGREEMENT

This Form is a legally binding Financial Agreement between Exodus Pain Clinic, PLLC ("Clinic") and the Patient.

I _____ understand that as a recipient of medical care I am responsible for all charges regardless of my circumstances for reimbursement.

I understand that a fee is charged for all visits, examinations, and/or treatments. I agree that the determination of the professional services to be rendered by my physician/provider and the fees to compensate him/her for these services are matters which concern my physician/provider and me. I understand that I have the primary duty and obligation to pay for the services rendered, notwithstanding any contract I may have with any third party payer (for example, insurance company, employer, etc.).

I authorize the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or my dependents.

I further expressly agree and acknowledge that my signature on this document authorizes my physician/provider and all necessary parties to submit claims to obtain benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as if the undersigned had personally signed the particular claim.

I hereby authorize my insurance company to pay and hereby assign directly to Exodus Pain Clinic, PLLC, all benefits. Insurance companies provide an explanation of benefits outlining payments and patient's financial responsibility under their contract with the patient. I understand I am financially responsible to the Clinic for all charges incurred and not paid by the third party insurance. I further acknowledge that any insurance benefits received by the Clinic, will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my personal responsibility. **PLEASE INITIAL EACH LINE.**

_____ I acknowledge that I have received a copy of the financial policy

_____ I understand and agree that all copayments are due and to be paid at the time of service.

_____ I understand and agree that there is a $30.00 service charge for a returned check.

_____ I understand and agree that full payment is due within 90 days from the date of service and are not contingent upon receiving a statement.

_____ I understand and agree that unpaid charges over 90 days will receive a letter for final demand of payment.

_____ I understand and agree that accounts with no activity for 120 days may be forwarded for further collection action, except as otherwise arranged with the Clinic, or mandated by law.

_____ I understand and agree that the Clinic will charge $50 for missed follow up appointments and $75 for missed procedure appointments that are not canceled within 24-hours prior to the patient's appointment.

_____ I understand and agree that should I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees. Any and all advance collection fees incurred by the Clinic will be included in my final bill.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING:

1. Providing Exodus Pain Clinic, PLLC, with complete and accurate billing information, including, but not limited to a current insurance card, authorization numbers, and/or referral forms for each visit and/or procedure. I am responsible for all visits and procedures not properly authorized.

2. I give my consent to Exodus Pain Clinic, PLLC to provide medical care and treatment to the below named patient deemed necessary and proper in diagnosing or treating his/her/my physical condition.

I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE:

SIGNED: (patient or guarantor)_____DATE: _____

FOR: (print patient name) _____