ASSIGNMENT OF BENEFIT, FINANCIAL RESPONSIBILITY AND CANCELLATION POLICIES

Last name _____ First name _____ DOB _____

Address _____ City _____ St _____ SSN _____

RELEASE OF INFORMATION: I authorize Valor Spine Solutions, LLC to disclose and release to my insurance carrier(s), as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

ASSIGNMENT OF BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to Valor Spine Solutions, LLC for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation. Late fees may apply.

AGREEMENT OF RESPONSIBILITY: I understand that *any patient cost share is due at the time services are scheduled* (estimated coinsurance and deductibles and cash pay). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance as well as attorney fees and costs to Valor Spine Solutions, LLC if this matter is referred to collection.

MEDICARE AUTHORIZATION: If a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

CANCELLATION/NO SHOW POLICY: Valor Spine Solutions, LLC requires 72 hours' notice for cancellations of any scheduled procedure. Any cancellations made within 72 hours of scheduled procedures will be subject to a 25% penalty

Patient signature _____ Print name _____

Date _____