iMsk & Spine Group
INTEGRATED MUSCULOSKELETAL, SPINE, AND REHAB MEDICINE

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Authorization/Assignment of Benefits

Please be advised that my signature on the bottom of this page acts as my acknowledgment of understanding of the items explained below.

1. Consent for treatment:

I, the undersigned, authorize iMsk & Spine Group, PLLC, and its designated employees to perform diagnostic tests, including but not Limited to radiographs, and to administer treatment as necessary. I further certify that no guarantees or assurances haven't made it to me regarding the results that might be obtained.

2. Financial Responsibility:

I understand and agree that all health and insurances policies are an arrangement between the insurance carrier and myself. I authorize the _____ insurance company shall submit by check all payments directly to **iMsk & Spine Group, PLLC, 73 Guy Lombardo Avenue, Freeport, NY 11520**, the expense benefits allowable and otherwise payable to me under my current policy, as payment towards the total charges for professional services rendered. I agree to pay, in a current manner, any balance of said applicable charges. I further agree that any payment made buy any insurance carrier directly to me it will be turned over to iMsk & Spine, PLLC, along with the explanation of benefits. The clinic agrees that it will assist me at no charge in the filing out of any insurance claim forms required. I further grant this office power of attorney to endorse any check permitted by name for that purpose for applying that amount to my account. **I FURTHER KNOWLEDGE THAT I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME OUR CHARGE DIRECTLY TO ME THAT I AM RESPONSIBLE FOR PAYMENT.**

3. Agreement to pay medical costs in the event of failure to prosecute or if compensation is disallowed.

I understand and agree to pay all medical costs in the event I fail to prosecute the claim for Worker's Compensation for the illness or condition, or does determined by Workers Compensation Board that the illness or condition is not the result of a compensable worker's compensation case

4. Attorney representation and protection of balance.

I understand that my signature below also authorized my attorney _____, or whomever I may retained at the time of settlement, and who excepts any settlement of any action I might have pending, to pay, in full any outstanding balance on my account. This agreement shall be considered irrevocable it is made out of consideration of the practices willingness to await payment of any outstanding balance, shall responsible for that outstanding balance due to practice for any medical treatment. I have also been advised that if my attorney does not wish to cooperate protecting the practices interest, the practice will not await payment; but will require me to make payments on all outstanding balances to maintain my account in a current status. I authorized this office to arbitrate or litigate my bills if necessary.

Patient Signature _____ Print Name: _____
(Or signature of Guardian or Relative)

Relationship to patient _____ Date: _____
(If signed by person other than patient)

Interpreter's Signature _____ Print Name: _____

Witness Signature _____ Print Name: _____