



ASSIGNMENT OF INSURANCE BENEFITS & APPOINTMENT OF AUTHORIZED REPRESENTATIVE

I hereby knowingly and voluntarily:

1. **Assign to Spine and Pain Institute of Nona, LLC, d/b/a Nona Spine and Pain Institute** (“Provider”) all applicable health insurance benefits and payments to which I or my dependents may be entitled for services rendered by Provider.
2. **Authorize direct payment** of authorized insurance benefits, including **Medicare**, if applicable, to the Provider.
3. **Appoint Provider as my Authorized Representative**, granting full authority to:
 - o File, pursue, and appeal insurance claims, grievances, and benefit determinations
 - o Communicate directly with my health plan and its administrators
 - o Pursue administrative remedies and, if necessary, initiate litigation or complaints against my health plan (including naming me as plaintiff when required)
 - o Access, use, and disclose my protected health information as necessary to pursue benefits and payment

I understand that Provider is **not responsible** for the terms, limitations, or determinations of my insurance plan.

I certify that all insurance information I provided is accurate and current and that I am responsible for promptly updating Provider with any changes.

I acknowledge that **insurance coverage does not eliminate my financial responsibility**, and I am personally responsible for all amounts not covered by my insurance, including **deductibles, co-payments, co-insurance, and secondary balance amounts**, including Medigap balances not paid.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Provider and any holder of my medical or billing information to:

- Release information necessary to process insurance claims and benefits
- Communicate with my health plan, Medicare, Medicare Administrative Contractors, and applicable government agencies
- Use copies or electronic reproductions of my signature for claims processing

This authorization remains effective until revoked by me in writing.

Authorization to Discuss Medical Information

I authorize Provider to discuss my medical care with the following individuals:

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____



Authorization to Discuss Financial Information

I authorize Provider to discuss my account and billing matters with the following individuals:

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

ERISA AUTHORIZATION

I designate Provider as my **Authorized Representative** under any applicable **ERISA-governed health benefit plan**, pursuant to **29 C.F.R. § 2560.503-1(b)(4)**, granting Provider the right to:

- Act on my behalf for all benefit determinations, appeals, and claims
- Pursue administrative remedies, reimbursement, penalties, and litigation
- Communicate directly with plan administrators and fiduciaries

This authorization remains in effect until revoked in writing.

A copy of this authorization shall be deemed as valid as the original.

PAYMENT POLICY & OUT-OF-NETWORK DISCLOSURE

I understand and agree that:

1. Provider accepts cash, checks, debit cards, credit cards, and approved financing programs (e.g., CareCredit).
2. Provider is an **out-of-network provider**.
3. I am responsible for:
 - All non-covered services
 - Any balance between the Provider’s charges and insurance payments
 - All deductibles, co-insurance, and patient responsibility amounts
4. The provider **cannot waive** the patient's responsibility required by law or insurance contracts.
5. Balances unpaid for **90 days** or more may accrue **interest at 1.5% per month**, compounded daily.
6. **Chargebacks are not permitted** for medical services rendered.
 - Any chargeback may result in legal action, and I will be responsible for associated costs and legal fees.
7. A **\$50 fee** will be assessed for returned checks.



NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Provider's **Notice of Privacy Practices**, which explains how my health information may be used and disclosed, and how I may access my information. I understand a copy is available upon request.

CANCELLATION & NO-SHOW POLICY

Provider strives to deliver timely, high-quality care. Missed appointments prevent other patients from receiving treatment.

Appointment Cancellations

- Appointments must be cancelled **at least 24 hours in advance**
- Failure to cancel timely manner will result in a **\$50 no-show/cancellation fee**
- Fees are **not covered by insurance**

Late Arrivals

- Patients arriving **15 minutes late** may be:
 - Seen if scheduling permits, or
 - Asked to reschedule


Procedures / Surgery

- Procedures must be cancelled **at least 48 hours in advance**
- Late cancellations or no-shows will result in a **\$100 fee**
- Fees are not billable to insurance

Account Balance Requirement

- Outstanding cancellation or no-show balances **must be paid in full** prior to scheduling future services
- Excessive cancellations or no-shows may result in **discharge from the practice**

To cancel appointments, contact Patient Services at:

 **(407)326-6898**

A cancellation confirmation number will be provided.

Medicare Advance Beneficiary Notice (ABN) Acknowledgment and Coordination of Benefits

Medicare Beneficiary Acknowledgment and ABN Coordination:

If I am a Medicare beneficiary, I understand that Medicare does **not** cover all services, procedures, tests, supplies, or treatments provided by **Spine and Pain Institute of Nona, LLC, d/b/a Nona Spine and Pain Institute**



("Provider"). I acknowledge that certain services may be deemed **not reasonable and necessary, experimental, investigational, frequency-limited**, or otherwise **non-covered** under Medicare guidelines.

I understand that when Provider believes Medicare may deny payment for a service, I will be issued a **Medicare Advance Beneficiary Notice of Noncoverage (ABN) (CMS-R-131)** prior to the service being rendered, when required by law. I acknowledge and agree that:

1. **Signing an ABN means I may be financially responsible** for the service(s) listed if Medicare denies payment.
2. I have the right to choose whether to receive or decline the services listed on the ABN.
3. If I elect to receive the services and Medicare denies payment, **I agree to pay Provider directly** for all applicable charges.
4. If I decline the services listed on the ABN, I understand that the Provider may not be able to deliver the recommended treatment.
5. ABNs apply **only to Medicare fee-for-service** and do not apply to Medicare Advantage plans unless otherwise required by the plan.

I further understand that routine notices or generic statements do **not** replace a properly executed ABN, and that each ABN applies **only to the specific service(s) and date(s)** identified therein.

Coordination with Secondary or Supplemental Insurance:

If I carry Medigap, secondary, or supplemental insurance, I understand that such coverage **does not guarantee payment** of Medicare-denied services. If Medicare denies a claim and my secondary insurance fails to pay all or part of the remaining balance, **I remain financially responsible** for all allowed charges.

Voluntary Receipt of Non-Covered Services:

I acknowledge that I may request services that are known to be non-covered by Medicare and that, in such cases, an ABN may not be required. I agree that I am financially responsible for the payment of such services.

For Medicare beneficiaries, financial responsibility for non-covered services is further governed by the Medicare Advance Beneficiary Notice (ABN) provisions described herein.

PATIENT ACKNOWLEDGMENT

I acknowledge that I have read, understand, and agree to the terms outlined above.

Patient Name (Print): _____

Patient Signature: _____ **Date:** _____