



## Assignment of Benefits

I agree to provide information regarding health insurance, workers' compensation, automobile, and other health care benefits to which I/the patient may be entitled. I/Patient assign(s) payment(s), if any, from my insurance carrier/health benefits plan to Capitol Spine & Pain Centers for services rendered. The direct payment assigned and authorized includes any medical insurance benefits to which the patient is entitled, including any Major Medical benefits otherwise payable to patient under the terms of the policy, but not to exceed the balance due for services rendered.

I understand that if my insurance carrier or health maintenance organization does not consider the services rendered to fall within its coverage, or has not authorized the services, then I will be fully responsible for the services provided. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay larger co-pay, co-insurance, or other charges. In the event that the insurance carrier does not reimburse these services provided, I acknowledge that I will be responsible for any balance that the insurance carrier declines to pay for such services.

Signature \_\_\_\_\_ Date \_\_\_\_\_