MD PAIN
SPORT, SPINE, AND PAIN MANAGEMENT

**PATIENT FINANCIAL RESPONSIBILITY STATEMENT**

Thank you for choosing Metro Denver Pain Management, PLLC ("MD Pain") as your healthcare provider. By asking MD Pain to provide you with medical services, you accept an obligation to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (e.g., parent, spouse, domestic partner) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing, and assure that they also sign below. By signing below and/or by receiving medical services from MD Pain, you, your representative and/or responsible party agree that:

1. I am ultimately responsible for all payment obligations arising out of my treatment or care and guarantee payment for these services. I am responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility required by my insurance carrier, which are not otherwise covered by my health insurance, including for services not covered by my insurance or for which my insurance carrier has denied coverage.

2. I am responsible for knowing the terms and coverage of my health insurance policy and understand that MD Pain cannot accept responsibility for collecting insurance payments or negotiating a disputed claim. While MD Pain may choose to assist me in such matters and, as a courtesy, may file insurance claims on my behalf, I remain solely responsible for the financial responsibility for services provided by MD Pain.

3. I will be solely responsible for any charges if any of the following apply: (i) my health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at MD Pain, and I have not obtained such an authorization or referral; (ii) I receive services in excess of such authorization or referral; (iii) my health plan determines that the services I received from MD Pain are not medically necessary and/or not covered by my insurance plan; (iv) my health plan coverage has lapsed or expired at the time I receive services at MD Pain; (v) if I request an office visit without a referral authorization, my insurance plan may deem this as "out of network;" or (v) I have chosen not to use my health plan coverage.

4. If I choose to self-pay for any services provided by MD Pain, (a) I assume responsibility for any violation of my health insurance policy for doing so; (b) I will notify MD Pain that I have elected to self-pay; and (c) I bear sole responsibility for requesting in writing an estimate of the anticipated cost of such services, upon the failure of which, I will not object to the charges billed by MD Pain for such services.

5. If I object to any payment obligations owed by me to MD Pain, I agree to assert such objection in writing no later than forty-five (45) days after my receipt of a statement setting forth such obligations, after which I waive my right to assert such objection.

6. I acknowledge and agree that,, in the event that any obligation owing by me to MD Pain which I have not paid and about which I have not objected remains unpaid for more than sixty (60) days from my receipt of a statement setting forth such obligation or if MD Pain commences collection proceedings under Paragraph 8, MD Pain, in its sole discretion and except in case of an emergency, may cease providing medical services to me until all such obligations have been paid.

7. Without waiving any obligation to pay, I irrevocably assign to MD Pain, for application to my bill for services, all of my rights and claims for medical benefits to which I or my dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to me. I authorize MD Pain to release my patient information as necessary to process any such claim to the necessary insurance companies and third party payors. I authorize the transfer of monies paid to MD Pain or to me or on my behalf or otherwise refundable to me, to be transferred to MD Pain to settle any indebtedness to MD Pain for which I am responsible.

8. Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, I understand that I am responsible for all costs of collection, including attorney's fees and court costs, and that MD Pain has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered.

**ACKNOWLEDGEMENT**

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the Metro Denver Pain Management, PLLC PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to its terms; (iii) I agree to pay all charges due (or to become due) to MD Pain for the below Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I fail to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law); (vii) MD Pain reserves the right to cease providing medical services as set forth in Paragraph 6; and (viii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report.

I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

**ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.**

| _____ | _____ | _____ |
|---|---|---|
| Patient/Guardian (Signature) | Date | Date of Birth |

_____

Patient/Guardian (Print)

_____

Responsible Party (Signature)

_____

Responsible Party (Print)