Conor W. O'Neill, M.D.

CALIFORNIA SPINE DIAGNOSTICS
2100 WEBSTER ST., SUITE 518
SAN FRANCISCO, CA, 94115
(415) 600-7830

Financial Agreement and Authorization Form

We thank you for choosing California Spine Diagnostics for your interventional pain services. The payment of your bill is an essential part of our financial relationship. In the course of your treatment, you may receive separate bills - the physician's professional services, the facility, imaging services and tests, or laboratory tests. The following is a statement of our physician's financial agreement which we require you to read and sign before rendering services.

Self Pay

You understand that you are legally responsible to pay the full charges for any and all care and service(s) rendered to you/the patient by California Spine Diagnostics.

Managed Care Health Plan

Your insurance may pay for this service, and frequently your insurance only pays a portion of the bill. You are responsible for your co-payment (due at the time of service), deductible, and any remaining balance that is not covered by your insurance. This balance is due within 30 days.

Non-covered Services

If we provide services to you that are not covered by your health plan, you will be responsible for payment in full for those services. Your signature, below, constitutes your agreement to pay for such services.

Medicare

We are a participating Medicare provider. You are responsible for your deductible and co-payment. If you have a secondary carrier, a portion of your co-payment may be covered.

Assignment of Benefits

This undersigned assigns and hereby authorizes direct payment to the California Spine Diagnostic Medical Group, Inc. of all insurance and plan benefits otherwise payable to or on behalf of the patient for services rendered. It is understood this he/she is financially responsible or charges not covered by this assignment.

Appointment Cancellation Charge

A full appointment fee may be charged for appointments or procedures cancelled without a minimum of two business day's notification.
(Please Initial: _____)

Payment Arrangements

Payments may be made in cash, by check or by Visa/Mastercard/American Express.

Collections

If it is necessary to assign your account to a collection agency and/or attorney, you will be responsible for all of our collection agency and attorney fees.

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov.

Authorization

The undersigned certifies that he/she has read the information above and has been given the opportunity to have any questions answered fully and to his/her satisfaction, and has received a copy of this financial agreement and authorization form. The undersigned further certifies that he/she is
1) the patient, or
2) the patient's legal representative, or
3) is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient Signature _____ Date _____ Printed Name _____

Responsible Party Signature _____ Date _____ Printed Name _____

Consent for Use and Disclosure of Health Information

By signing this section, you acknowledge receipt of the *Notice of Privacy Practice*. Our *Notice of Privacy Practices* provides information about how we may use or disclose your/the patient's protected health information to carry out treatment, payment activities, and health care operations. We encourage you to read it in full.

Signature _____ Date _____