Curis
Pain & Wellness
It's Your Life. Live it Well!

*6727 Hwy 431 S, Suite L, Owens Cross Roads AL 35763* *256-489-2870*

**AUTHORIZATIONS**

A. I hereby authorize release of any medical information necessary to process claims and request payment of insurance benefits either to myself or to the party who accepts assignment.
B. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to e paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter woe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.
D. I authorize you to furnish Curis Pain and Wellness, or anyone designated in writing by them, all records, opinions, reports, x-rays, photostatic copies, abstracts of any records or any other information or documents they may request that you may have in your custody or under your control regarding the patient whose name appears below.

Print Name: _____DOB: _____SS#_____

Patient Signature: _____Date: _____

Guardian Signature: _____Date: _____

**ASSIGNMENT AND RELEASE**

I, the undersigned, certify that I have insurance coverage with the insurance company(s) stated on the information provided to me and I have given it to the receptionist. I also assign directly to "*Curis Pain and Wellness*" all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the release of any medical information necessary to process claims. **I understand that I am financially responsible for all charges whether or not paid by insurance as well as any co-pays, deductibles, or non-covered services that may occur. I also understand that I will be billed to my home/post office address for any balances outstanding. I agree to make full and complete payment within 30 days** of denial of a claim by my insurance company. I also request payment of any government benefits to "*Curis Pain and Wellness*" per their agreement to accept assignments.

I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Date: _____ Signature of Patient/Guardian: _____