

Central Arizona Pain Institute
Interventional Spine & Pain Management
2100 Centerpointe West Drive
Prescott, AZ 86301

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www.centralazpain.com

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FINANCIAL RESPONSIBILITY FORM

I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize this signature on all insurance submissions.

CONSENT TO CONTACT

I consent and authorize Central Arizona Pain Institute and its related entities, agents, contractors, including but not limited to schedulers, billing, and other staff to use automated telephone dialing systems, SMS text messaging, and electronic mail to

(1) provide messages (including pre-recorded messages or text messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or

(2) provide messages (including pre-recorded messages) during a call or via text message that delivers a "healthcare" message made by, or on behalf of, a "covered entity" or its "business associate as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103.

_____ Initial

THIRD PARTY COLLECTION FEE CONSENT

I agree to pay all charges and/or co-payments at the time of service. In the event of default, I agree to pay all legal fees, collection fees, and/or interest that may be incurred in the collection of my account(s).

_____ Initial

Signature

Date

Printed Name