CENTRAL FLORIDA PAIN & REHAB CLINIC
www.cfprc.com

3727 N. Goldenrod Rd. #103
Winter Park, FL 32792
Phone: 407-673-9533
Fax: 407-673-1442

ACKNOWLEDGEMENT OF LIABILITY ASSIGNMENT OF BENEFITS

- **FINANCIAL STATEMENT:** The undersigned patient and/or responsible party, hereby acknowledge personal responsibility and liability for all the medical services, which are provided by **Central Florida Pain & Rehab Clinic**.
  This personal obligation is not affected by any obligation of insurance companies to pay health care costs. I understand that **Central Florida Pain & Rehab Clinic** will process an initial claim for all services rendered to me and file it with my insurance carrier. Therefore, I authorize and request that my insurance carrier pays DIRECTLY to **Central Florida Pain & Rehab Clinic** all insurance benefits otherwise payable to me.
  I also understand and agree that my insurance policy is a contract between myself and my insurance carrier and I am ultimately financially responsible for payment of all services rendered to me, which my insurance carrier has not paid (within 90 days) or for services which my insurance carrier has determined not to be covered by my policy.

- **CONSENT FOR TREATMENT**: The undersigned hereby consents to the provision of examination, fitness evaluation, treatments, therapies, medical procedures, drugs and supplies to the patient as ordered by the patient's health care provider of **Central Florida Pain & Rehab Clinic** of their physician, physical therapist, certified athletic trainer or staff, and acknowledges that no guarantee or assurance has been made to the results of such treatments, procedures or examinations.

- **RELEASED INFORMATION: Central Florida Pain & Rehab Clinic** provided me with a Notice of Privacy Practice that gives a complete description of information, uses and disclosures. I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

- **ASSIGNMENT OF RIGHTS**: I assign exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity to the extent of my bill for total services, including exclusive, irrevocable right to receive payment for such services, make demand in my name for payments and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance company or other person or entity. I as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and/or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy and any information supporting documentation concerning or touching upon handling, calculation, procession, or payments of any claim.

- **PAYMENTS AND COLLECTION FEES:** I clearly understand and agree that if I do not pay the entire new balance within 30 days of the monthly billing a late charge of 1.5% on the balance then unpaid and owed will assessed each month (if allowed by law) I realize that failure to keep my account current may result in **Central Florida Pain & Rehab Clinic**, being unable to provide additional services except for emergencies or where there is a CASH pre-payment for additional services. In the case of default on payment on my account, I agree to pay collection cost (35%) and reasonable attorney fee incurred in attempting to collect on this amount or any future outstanding account balances. I also understand that **Central Florida Pain & Rehab Clinic** may charge an administrative surcharge of **$15.00** for processing your co-insurance and/or deductible amounts after your visit.

- **MISSED APPOINTMENTS**: I clearly understand and agree, that in order for the evaluation and treatment of my current pain problem (s) to be effective, it is extremely important for me to keep my scheduled appointments. I realize that this time has been exclusively reserved for me and agree that if I am unable to keep my appointment I will give **Central Florida Pain & Rehab Clinic**, at least 24 hours advance notice. I understand that failure to do such indicates non compliance to my recommended plan of treatment and may result in being charged for a "MISSED" appointment fee.

In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of the Agreement shall remain enforceable. A PHOTOCOPY OF THE INSTRUMENT SHALL SERVE AS ORIGINAL.

_____	_____	_____
Printed Name	Signature	Date

Spanish Version: Por motivos legales el consentimiento del paciente debe estar consignado en este documento en inglés, pero si usted no tiene claridad con respecto a algo aquí relacionado, favor solicite la versión en español del mismo a nuestro personal.