ALLIED PAIN INSTITUTE
FIGHTING PAIN. TOUCHING LIVES.

JAMES PETROS, M.D., INC.
PHONE: (408) 528-8833 | FAX: (408) 528-8557

ALLIED PAIN INSTITUTE
14777 Los Gatos Blvd., Suite 202, Los Gatos, CA 95032

ALLIED HEALTHCARE CLINIC
2724 Aborn Rd. San Jose, CA 95121

Patient Financial Responsibility

Patient Name: ______________________________ **DOB:** ____________

We appreciate the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any **deductible and co-payment/co-insurance** as determined by your contract with your insurance carrier. These fees are expected at time of service. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance.

I have read the above policy regarding my financial responsibility to JAMES PETROS, M.D.,Inc., for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to JAMES PETROS, M.D.,Inc., the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature ______________________________ **Date** ____________

Guarantor Signature ______________________________ **Date** ____________

(If guarantor is not the patient)

Consent for Treatment and Authorization to Release Information

I hereby authorize JAMES PETROS, M.D., Inc., through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize JAMES PETROS, M.D., Inc., to release to appropriate agencies, any information acquired in the course of my or the above named patient’s examination and treatment.

Patient/Guarantor Signature ______________________________ **Date** ____________

Assignment of Benefits

As your provider, we will be accepting assignment on all services and procedures. i.e., provider receives reimbursement directly from the payer. However, due to a loophole in the system, some insurance companies refuse to honor assignment of benefits when patients use their out-of-network PPO benefits and, instead, pay the patient directly. I agree to sign over any insurance payments made out to me/Subscriber. I have read and understand the above information, and agree to the terms described.

Patient/Guarantor Signature ______________________________ **Date** ____________

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Allied Healthcare Clinic. I agree to pay Allied Healthcare Clinic, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature ______________________________ **Date** ____________