Benefit Release Information: I authorize **Desert Spine and Sports Physicians, PLLC** to release any information necessary to my insurance carrier and/or their agents in order to determine benefits payable for related services. I authorize the payment of medical benefits for these services to be paid directly to **Desert Spine and Sports Physicians, PLLC.** I authorize the release of all clinical information to my referring physician and primary care physician so that he or she can be updated on my condition and the care I receive here.

Initials: _____

Financial Responsibility: I am the person financially responsible for any debt in relation to services provided. I understand and agree to pay all insurance co-pays and amounts due for services not covered by insurance in advance at the time of service. I understand and agree that, except as otherwise provided by law, I am obligated to pay any charges that are not paid by my insurance company within 60 days or immediately upon denial by my insurance company. Should this account be referred to any attorney, I agree to pay reasonable attorney's fees. Should this account be referred to a collection agency I agree to pay a collection charge of 35% of the balance submitted to collection. All delinquent accounts are eligible to bear interest.

Initials: _____

Authorization of treatment: I authorize **Desert Spine and Sports Physicians, PLLC** to provide medical services to myself or to _____(my legal dependent). I understand I have the right to refuse medical services at any time. I further understand no guarantees have been made by any representative of **Desert Spine and Sports Physicians, PLLC** as to the outcome of this medical service.

Initials: _____

Cancellations and No-Shows: We require 24 hours notice of a cancellation of an initial or follow-up visit. We require 48 hours notice of a cancellation of an electrodiagnostic test (aka. EMG). There will be a $50.00 charge for a cancellation or no show of an initial or follow-up visit without proper notice. There will be a $100.00 charge for a cancellation or no show of an electrodiagnostic test without proper notice. These charges will not be covered by your insurance plan and is your responsibility. For Worker's Compensation patients, you are required to document any cancelled or missed appointments and forward to your case manager and primary care physician.

Initials: _____

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

(If the patient is a minor, please have the parent sign here.)