



JACKSONVILLE  
PAIN CENTER

.....Center for excellent care

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### **Release of information consent**

I authorize Jacksonville Pain Center to release any information acquired in the course of my examination or treatment to my insurance company, to a hospital, to which I am admitted or to a referral physician or other physician, and permit payments to be made directly to them, at their election, of any benefit due me for the services rendered.

I accept and recognize responsibility for any balance remaining after the payment of such benefit. I also understand that a copy of this statement can be used as valid proof.

The assignment of insurance monies does not alter the undersigned obligation to pay. I understand that all charges resulting from said treatment are due when statements are presented- including that portion of that charges covered by that insurance company, given reasonable length of time.

I, the undersigned, agreed to pay all cost of collection, and suit be necessary to enforce collection, pay all cost of said suit to gather with a reasonable attorney fee and court cost.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

### **Assignment and Release**

I, the undersigned, have insurance with \_\_\_\_\_ and assign directly to Dr. Hemant Shah all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether of not paid by insurance. I hereby authorized the doctor to release all information necessary to secure payment of the benefit. I authorized the use of the signature in all my insurance submissions.

\_\_\_\_\_  
Patient / responsible party Signature

\_\_\_\_\_  
Date