

**DISCLAIMER:**

**Filling out this form and emailing to the physician does not create a physician patient relationship until the patient is physically seen by the physician.**

**ASSIGNMENT AND RELEASE**

I, the undersigned have insurance coverage with \_\_\_\_\_

\_\_\_\_\_  
Name of Insurance Carrier

And assign directly to Commonwealth Pain Specialists, L.L.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to pay all balances due by me, including charges for no-show visits and cancellations that were not given with more than 24 hours notice. The schedule of payments for no-show and cancellations within 24 hours is \$25 per appointment for established patient visits \$50 per appointment for new patient visits, and \$100 per procedure visit. All accounts are considered delinquent after 30 days and will be assessed a 1.5% per month, 18% per year finance charge. I further agree to pay any collection, attorney, or court costs involved in collecting for nonpayment on my account. I authorize Commonwealth Pain Specialists, L.L.C. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.



\_\_\_\_\_

Beneficiary Signature

**RELEASE**

I further authorize the physicians of Commonwealth Pain Specialists, L.L.C. to forward medical information to my primary and /or other referring physicians and any other provider deemed necessary for my medical care or to whom I may be referred. I authorize the electronic or faxed submission of medical records and claims submitted.



\_\_\_\_\_

Beneficiary Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Witness

\_\_\_\_\_

Date

**MEDICARE AUTHORIZATION**

\_\_\_\_\_

NAME OF BENEFICIARY

\_\_\_\_\_

MEDICARE I.D. NUMBER

I request that payment of authorized Medicare benefits be made on my behalf to Commonwealth Pain Specialists, L.L.C. for any service furnished to me by the physician. I authorize release to the Health Care Financing Administration and its agents any medical information about me needed to determine the payment for related services.



\_\_\_\_\_

Beneficiary Signature