SPINE INSTITUTE OF CENTRAL FLORIDA
WORLD-CLASS SPINE CARE
EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY
Comprehensive Center of Excellence in ALL Spine Care & Pain Management

Chukwuka C. Okafor, MD, MBA, CIME
German Marulanda, MD
Colby Fagin, MD

5050 South Florida Avenue | Lakeland, Florida 33813
1218 Millennium Parkway | Brandon, Florida 33511
131 Webb Drive, Suite B | Davenport, Florida 33837
Phone: (863) 688-3030 | Fax: (863) 688-4430
www.SpineInstituteFL.com

Spine Institute of Central Florida
Lifetime Authorization Statement Assignment of Benefits for Direct Payment

Patient Name:_____ Date:_____

Policyholder/Insured: _____

Spine Institute of Central Florida, which will hence forth be referred to as SICF, is pleased that you have selected this group to provide for your medical needs. Please review the following Lifetime Authorization Statement. Please do not hesitate to ask a staff member for clarification on any part of this document. Please sign where indicated and return it to the receptionist. If you disapprove, we certainly respect your right of refusal. Signing this form will not increase patient financial responsibility; however, without your signature your insurance may not pay SICF for the services provided. This will leave the full billed charges as patient financial responsibility. Therefore, we will have no alternative but to require that you be responsible for the cost of services rendered in full, prior to the service being rendered to you. Should you refuse this option, we have no other choice than to cancel your appointment. Thank you very much in advance for your cooperation.

Assignment of Insurance Benefits; Financial Responsibility

SICF will work for and with you in an effort to obtain proper reimbursement from your insurance plan. An assignment of benefits will assist SICF in working with your insurance plan.

I assign all applicable health insurance benefits to which I and/or my dependents are entitled, to SICF. I certify that the health insurance information I have provided is accurate as of the date set forth below and that I am responsible for keeping it updated. I will use my best efforts to assist with submitting insurance claims.

I authorize SICF to submit claims, on my and/or my dependent's behalf, for payment to Medicare, or any other payer for services provided to me or my dependent. I also instruct my benefit plan (or its administrator) to pay SICF directly for the services rendered to me or my dependent. To the extent that my current policy prohibits direct payment to SICF, I instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and SICF upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to SICF.

I assign the right to appeal payment denial or other adverse decisions made by my benefit plan (or its administrator), as well as the right to file a complaint or grievance, bring suit, or pursue arbitration, to SICF on my behalf.

I understand that I am financially responsible for the billed charges for the services provided to me by SICF, regardless of my insurance coverage, and in some cases may be responsible for an amount in addition to that which is paid by my insurance, such as co-pay, co-insurance, deductible, and any remaining balance. I agree to immediately remit to SICF any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to SICF.

Lifetime Authorization Statement/Assignment for Direct Payment

I hereby instruct and direct my current insurance carrier to pay by check made payable to:
Spine Institute of Central Florida 5050 South Florida Ave, Lakeland, FL 33813

For the medical, surgical, and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to SICF. I have agreed to pay, in a current manner, any balance of said service charges over and above this insurance payment, including applicable co-payments, deductible, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is
limited by agreement or law applicable to SICF. A photocopy of this assignment shall be considered as effective and as valid as the original.

I understand that SICF does accept assignment for Medicare and payments will be directed to SICF. Should my account be referred for collection procedures, I will also pay reasonable attorney's fees and collection expenses.

Consent for Treatment

I authorize Spine Institute of Central Florida to provide treatment as necessary for which I am, or my minor child, is being seen. This includes, but is not necessarily limited to evaluations, radiographic services, injection, fracture care, casework, rehabilitation, or any other treatment deemed proper care of my injury, condition, or illness.

SPINE INSTITUTE OF CENTRAL FLORIDA
WORLD-CLASS SPINE CARE
EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY
Comprehensive Center of Excellence in ALL Spine Care & Pain Management

Chukwuka C. Okafor, MD, MBA, CIME
German Marulanda, MD
Colby Fagin, MD
5050 South Florida Avenue | Lakeland, Florida 33813
1218 Millennium Parkway | Brandon, Florida 33511
131 Webb Drive, Suite B | Davenport, FL 33837
Phone: (863) 688-3030 | Fax: (863) 688-4430
www.SpineInstituteFL.com

Authorization to Release Information

I hereby authorize Spine Institute of Central Florida to release any medical information in connection with these services to any person or corporation which is or may be liable for all or any portion of the charges, including insurance companies, health care service plans, workers' compensation carriers, adjusters or attorneys, to the extent necessary to obtain reimbursement; Also to my personal physician, referring physicians, or primary care physician. **I am aware that any/all information contained within my medical records/chart is the Property of Spine Institute of Central Florida.** SICF may need to obtain information from other sources in order to receive appropriate reimbursement from all available insurance sources.

Request for Insurance Disclosure

I authorize and direct any holder of medical information or documentation that may include city, county, and state accident reports about me or my dependent to release such information to SICF, its billing agents, CMS, its carriers and agents and/or any other payers or insurers as may be appropriate to determine any benefits payable for these or any other medical services provided to me or my dependent by SICF.

Pursuant to Florida Statutes Section 627.4137 relating to disclosure of insurance information, I am requesting the required statement under oath of a corporate officer, insurer's claims manager, or superintendent setting forth the following information regarding each known insurance policy, including umbrella or excess insurance: a) name of each insurer b) name of each insured c) limits of liability coverage d) limits of uninsured motorist coverage e) a statement of any policy or coverage defense f) a copy of each policy. Please respond by sending the requested information to 5050 South Florida Avenue Lakeland, FL 33813 or by fax at 863-688-4430 within 2 weeks.

ERISA Authorization (Only Applies to Employer Sponsored Plans):

I hereby assign and designate SICF to act as my agent and/or authorized representative, to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("EIRSA"). I grant SICF the right to act on my behalf, as my agent, for the purpose of obtaining payment and/or reimbursement for all medical treatment and/or services rendered to me by SICF and its affiliates; including but not limited to: (a) make claims against insurers or other third-party payors; (b) initiate, prosecute, and/or defend litigation, arbitration, and all other legal remedies; (c) enforce my rights to benefits; (d) sue on my behalf; (e) recover expenses, damages, legal fees, penalties or fines, and interest fees from my insurer; and (f) pursue and receive benefits and direct payment from my insurer and/or third-party payor(s).

I further assign SICF and its affiliates the right to pursue any available administrative appeals on my behalf, and to pursue any cause of action, with respect to any healthcare expense(s) incurred as a result of the service(s) I or my dependent received or will receive from SICF; including claims for violations of ERISA, to the extent permissible by law. These rights include all rights to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies.

To the extent that the applicable insurance policy and/or employee health care benefit plan lawfully prohibits any such assignments described above, I authorize SICF to take the above actions on my behalf. I assign to SICF the right to act as my agent and/or authorized representative, enforce my rights to benefits, and pursue and receive direct payment from my insurer.

Additionally, I have granted SICF limited power of attorney to act on my behalf, for the purpose of enforcing my rights to benefits, obtaining payment and/or reimbursement for all medical treatment and/or services rendered to me by SICF and its affiliates; as well as arbitrate, make claims, sue, and initiate or continue any and all other legal remedies on my behalf, recover expenses, damages, legal fees, penalties, interest, fines from my insurer, and pursue and receive benefits and direct payment from my insurer or third-party payer. I have granted SICF full authority to act in any reasonable and necessary manner for the purposes of exercising the above powers. I understand and fully agree to grant this power for purposes described.

The undersigned certifies that he/she has read and fully understands all the above, and as the patient, guarantor, or the patient's responsible party, fully agrees to and accepts all the terms above.

Signature of Patient/Responsible Party Signature of Witness Date

[ ] Witness reviewed patient identification, which clearly matched identify of Signator, and witnessed signature. ____

SPINE INSTITUTE
OF CENTRAL FLORIDA
WORLD-CLASS SPINE CARE
EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY
Comprehensive Center of Excellence in ALL Spine Care & Pain Management

Chukwuka C. Okafor, MD, MBA, CIME
German Marulanda, MD
5050 South Florida Avenue| Lakeland, Florida 33813
1218 Millennium Parkway | Brandon, Florida 33511
Phone: (863) 688-3030 | Fax: (863) 688-4430
www.SpineInstituteFL.com

Spine Institute of Central Florida Irrevocable Assignment for Insurance Benefits and Assignment of Lien for Medical Services Rendered

Patient Name:_____ Date:_____

Policyholder/Insured: _____

I hereby assign to Spine Institute of Central Florida any and all rights I may have to insurance benefits. This Assignment includes any and all Personal Injury Protection coverage (PIP), health, disability, liability coverage, self-insurance, workers' compensation, or other insurance coverage.

I authorize and direct my insurance carrier or any insurance carrier, including third-party carriers responsible for payment in whole or in part of my health care bill; to pay directly Spine Institute of Central Florida all the insurance benefits otherwise payable to me, the patient, but not to exceed Spine Institute of Central Florida's usual and customary charges.

This assignment includes my right to obtain automobile crash reports, to file insurance claims, and to take all remedies to enforce payment of the insurance proceeds. I understand Spine Institute of Central Florida is under no obligation to bring any action against any party on its behalf, or on my behalf.

If I receive or become entitled to receive any monies from any source whatsoever for my injuries, either through a lawsuit, settlement of a lawsuit or claim, awarded by a court or arbitrator(s), jury verdict or payment of insurance proceeds, I hereby assign and agree to pay said funds to Spine Institute of Central Florida (at the address listed above to the extent of any outstanding amounts then owed by me to Spine Institute of Central Florida for medical services before any other fees, costs or expenses are disbursed from any said funds. I further agree that the fee for the services to be performed by Spine Institute of Central Florida shall constitute a lien on any claim or lawsuit I may have as a result of my injuries and any settlement, award, jury verdict, or insurance proceeds that I receive or become entitled to receive as a result of my injuries.

This Assignment and Lien shall be placed in my chart and a copy thereof shall constitute actual notice to my attorney, or any other person, that my medical bills to Spine Institute of Central Florida shall be paid first from the proceeds of any such lawsuit, settlement, award, jury verdict or insurance. This authorization cannot be modified unless it is in writing and signed by both parties. I understand that I remain personally responsible for the payment of all fees owed by me to Spine Institute of Central Florida and that notwithstanding this Assignment and Lien, Spine Institute of Central Florida is not required to look to any other person or entity for payment.

I have given authorization to Spine Institute of Central Florida to forward a copy of this document to my attorney. This assignment and Lien shall be effective regardless of whether it is countersigned by any such attorney.

I fully understand that any and all care and services that is provided by SICF is being provided in reliance to this agreement.

The undersigned certifies that he/she has read and understands all the above, and as the patient, guarantor, or the patient's responsible party, agrees to and accepts the terms.

_____

Signature of Patient/Responsible Party Signature of Witness Date