SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, ACKNOWLEDGEMENT OF PRIVACY PRACTICES, DISCLOSURE OF FINANCIAL INTEREST

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Integrated Pain and Neuroscience, LLC for services furnished by Integrated Pain and Neuroscience, LLC. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. If I have other insurance coverage, my signature authorizes releasing the information to the insurer or agency shown. Integrated Pain and Neuroscience, LLC accepts the Medicare allowable determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services.
2. **PARTICIPATING INSURANCE AND RELEASE OF INFORMATION:** I understand that Integrated Pain and Neuroscience, LLC may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or other third party. Integrated Pain and Neuroscience, LLC may also tell my health plan and/or referring physician about a treatment I am going to receive to obtain prior approval or to determine whether my plan will cover the treatment, to facilitate payment, or the like.
3. **NON-PARTICIPATING WITH PATIENT'S INSURANCE:** The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to be by Integrated Pain and Neuroscience, LLC if I belong to a plan that Integrated Pain and Neuroscience, LLC does not participate with.
4. **NON-COVERED SERVICES:** The undersigned accepts full financial responsibility for all items and services which are determined by my insurance plan not to be covered. The undersigned agrees to cooperate with Integrated Pain and Neuroscience, LLC to obtain necessary healthcare service plan authorizations.
5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Integrated Pain and Neuroscience, LLC. I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Integrated Pain and Neuroscience, LLC for payment.
6. **FINANCE CHARGES:** I agree to pay a finance charge of 1% per month, compounded, for any balance I am responsible for which is over 60 days old. I also agree to pay for any returned check fees incurred by Integrated Pain and Neuroscience, LLC. It is the policy of Integrated Pain and Neuroscience, LLC to charge a non-refundable fee no less than $25.00 for checks that are returned. I understand that Integrated Pain and Neuroscience, LLC has the right to charge a non-refundable fee of no less than $25.00 for any missed appointment (visit, orientation, consultation, procedure, etc.) not cancelled 24 hours in advance. I also agree that if I am the parent/guardian bringing a child in for treatment that I am responsible for all fees incurred by the child. If an account is sent to a collection agency or attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Integrated Pain and Neuroscience, LLC. If co-payments and/or deductibles are designed by my insurance company or health plan, I agree to pay them to Integrated Pain and Neuroscience, LLC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.
7. **ACKNOWLEDGEMENT OF PRIVACY PRACTICES:** I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Integrated Pain and Neuroscience, LLC. There is also a copy posted in the office. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer.
8. **CONSENT:** I hereby authorize the doctors and staff of Integrated Pain and Neuroscience, LLC to administer or perform medical treatment including procedures or services as the may deem necessary or reasonable, including laboratory services and diagnostic procedures. Additionally, I authorize Integrated Pain and Neuroscience, LLC to obtain my medication history.
9. **DISCLOSURE OF FINANCIAL INTEREST:** Louisiana law requires physicians to disclose to a patient, when the physician refers the patient to another health care provider or facility, that the physician has a financial interest in that entity. The purpose of this disclosure is to notify you that Eric Royster, MD has an ownership interest in Old Gretna Pharmacy, LLC and The Wellness Corner, LLC. Dr. Royster also has an ownership interest in Alliance Surgery Center, LLC. If you are referred to one of these entities and have any questions, please discuss this with your physician directly. You have the right to choose a different entity or choose not to receive the services by letting the doctor know prior to the referral.

PATIENT SIGNATURE____

SIGNATURE OF PATIENT'S REPRESENTATIVE____________________ ____________________

Relationship to Patient

PATIENT NAME (PRINT)______________________________**DATE**____________