Coastal Spine and Rehab Center

5900 Argerian Dr. • Ste#102 • Wesley Chapel, Florida 33544
•
Ph 813-373-5317 Fax 813-373-5314
13910 Fivay Rd. • #10 • Hudson, Florida 34667 •
Ph 727-862-3509 Fax 727-862-3500

Financial Responsibility Statement

Insurance is a way for you to receive repayment for fees you have paid to a physician for services rendered. Having insurance is not a substitute for payment even though insurance companies have a fixed allowance or percentage based on your policy with them, **your policy is with your insurance company, not with this office**!

It is your responsibility to provide payment *for* the deductible, co-insurance, and any other balances not paid for by your insurance.

We will assist you in receiving reimbursement in any way possible, but you are ultimately responsible for the payment of your bill.

Primary Insurance _____ Effective Date _____

Address _____ City/State/Zip _____

Policy # _____ Group # _____ Phone # _____

Insured _____ Relationship to Insured _____

Secondary Insurance _____ Effective Date _____

Address _____ City/State/Zip _____

Policy # _____ Group # _____ Phone # _____

Insured _____ Relationship to Insured _____

I authorize the release of all medical records needed to process this clam and that is pertinent to my medical care I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to **Coastal Spine and Rehabilitation Center LLC**. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND IT.

Patient: _____ _____
(If patient is a minor a parent's signature is required) (responsible party)

_____ _____
(witness) (date)