SPINE INSTITUTE OF CENTRAL FLORIDA
WORLD-CLASS SPINE CARE
EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY

Chukwuka C. Okafor, MD, MBA, CIME
German Marulanda, MD
5050 South Florida Ave. | 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
LIFETIME AUTHORIZATION STATEMENT ASSIGNMENT OF BENEFITS FOR DIRECT PAYMENT

PATIENT NAME:_____ MR#:_____

Spine Institute of Central Florida 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. However, please be aware that, without your legal signature, we cannot file with your insurance carrier for the services you are scheduled to receive. Therefore, we will have no alternative but to require that you be responsible for the cost of services rendered in full. (See reverse side for Refusal to Sign Lifetime Authorization Statement). Should you refuse this option, we have no other choice than to cancel your appointment. Thank you in advance for your cooperation.

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
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 Spine Institute of Central Florida and 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 Spine Institute of Central Florida. A photocopy of this assignment shall be considered as effective and as valid as the original.
I understand that Spine Institute of Central Florida does accept assignment for Medicare and payments will be directed to Spine Institute of Central Florida. 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, injection, fracture care, casework, rehabilitation, or any other treatment deemed proper care of my injury, condition or illness.

RELEASE OF MEDICAL RECORDS

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 the patient's personal physician, referring physicians, or primary care physician. **I am aware that any/all information contained within my medical records/chart is Property of Spine Institute of Central Florida.**

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

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ASSIGNMENT AND LIEN FOR MEDICAL SERVICES RENDERED DUE TO AN ACCIDENT – RELATED TO AUTO, WORK COMP OR OTHER

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, aware 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, aware, 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.

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