Name: _____
DOB: _____
Date: _____

PERMISSION TO RELEASE INFORMATION & ASSIGNMENT

I have read and agree to the following:

1. Provide a current, personal and private email address that only you have access to. By providing an email address, you agree to have Southern Oregon Spine Care provide you with secure access to your health information.

   Email address:_____(Not Required)

2. Assign to the Physicians at Southern Oregon Spine Care all payments to which I am entitled for medical and surgical expense related to the service performed by them, and direct that checks for such services be made payable to them._____Initial

3. Authorize the above physicians to release such information as may be required by my attorney and/or my insurance company and/or referring doctor._____Initial

4. I understand that I am responsible for the payment of the bill, regardless of whether the charges may be covered by insurance in or out-of-network, or also be the responsibility of some other party. This includes supplies that I may receive that are not covered by Medicare or other plans._____Initial

5. If the problem for which you are seeing one of our doctors involves litigation, as may result from an automobile accident or liability, be advised that we do not wait for payment until the litigation is settled. We will accept monthly payments on your account excluding worker's compensation._____Initial

6. EPrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. I hereby provide informed consent to Southern Oregon Spine Care to enroll me in the ePrescribe Program, if I am not already enrolled._____Initial

7. I agree that Southern Oregon Spine Care may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes._____Initial

8. I authorize Southern Oregon Spine Care and its staff, to leave detailed messages at the primary phone number provided _____Initial

9. A 24 hour notice is required for any cancellations or reschedules. If you no-show for your appointment 2 times, you may not be able to reschedule. If you're more than 10 minutes late to your appointment it will be cancelled. _____Initial

10. **If you are unable to pay your balance due to a large amount, we may set you up on a payment plan to be satisfied within a maximum of 90 days. If you default on you payment plan the agreement will be void and the account will automatically be turned over to a collection agency without further notification to you. Once set up on a payment plan any additional office visits must be paid in full at the time of service or appointment will be cancelled. _____Initial**

11. I understand that my information will be shared with SOSC's third party billing service(s) providers, *Physource Billing Solutions* and *Specialty Care Management Services* _____Initial

Signature of patient or legal guardian:_____

Date:_____