For all patients: Revised October 23th, 2018
For all services (regardless of date of service) rendered at Coastal Spine

OUT-OF-NETWORK ADVANCE PATIENT NOTICE FORM

You are seeking services from Coastal Spine, P.C. Coastal Spine, P.C is out-of-network with your insurance company.

By placing my signature on this waiver form below, I acknowledge the following:

1. I am aware that Coastal Spine P.C., is out-of-network and does not participate with my insurance company.

2. I understand that the amount or estimated amount that Coastal Spine, P.C. will bill for the services to be provided is available upon my request. If requested, Coastal Spine, P.C. will provide me with the Current Procedural Terminology (CPT) codes and charges associated with the services that I am expected to receive, absent unforeseen medical circumstances that may arise.

3. I understand that I am financially responsible for the costs applicable to my health care services in excess of my copayment, deductible, or coinsurance. Additionally, I may be responsible for any costs in excess of those allowed by my health benefits plan.

4. It is advised that I contact my insurance carrier before obtaining services: (i) for further consultation on costs and ii) to obtain prior authorization if needed.

5. I understand that associated services may also be out-of-network. If I am to receive anesthesiology, laboratory, pathology, radiology, or assistant surgeon services, I was provided with the contact information for those providers. I understand that I should contact my insurance carrier to determine the related costs and the network status of these additional providers.

6. I am now knowingly, voluntarily, and specifically selecting Coastal Spine, P.C. as my provider on an out-of-network basis.

Print Name: ____________________ Date: ____________________

Patient Signature:_________________

Thank you!
Coastal Spine Billing Office

Member Consent for Provider to File an Appeal on my behalf with Health Insurance Plan

1. Provider Name: ___Coastal Spine, PC____
2. Provider Plan ID Number: __01-0767058____
3. Provider Address: _4000 Church Road Mount Laurel, NJ 08054_______________________
4. Provider Phone Number: _(856) 222-4444____
5. Description of services that are being appealed:
   ____

   ____
6. Date(s) services were or are to be provided: ____
7. I agree to allow this health care provider to file an appeal on my behalf with the following health plan, if there is a question about coverage for the services listed above.
8. I understand that:
   - If I consent, I will not be able to file my own appeal concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing.
   - I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
   - This consent shall be automatically rescinded if my health care provider does not file an appeal, or discontinues my appeal.
   - I have read this consent or have had it read to me, and it has been explained to my satisfaction.
9. I understand the information in the consent form, and grant my consent to this provider to file an appeal on my behalf.

Please fill out the information below:

a. Member Signature: ___________________________ b. Signature Date: _________________

c. Print Member Name: ___________________________ d. Member Date Of Birth: _________________

e. Health Insurance Company: _____________________ f. Member ID#: ___________________

g. Member Address: ____

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY FORM

Assignment of Benefits and Claims

I hereby assign and transfer to Coastal Spine, P.C. and/or its physicians all of my rights, title and benefits payable by my insurance carrier and/or benefits plan for services performed by Coastal Spine, P.C. and/or its physicians.

I hereby authorize Coastal Spine, P.C. and/or the physicians to submit claims to my insurance carrier or intermediary for all services rendered by Coastal Spine, P.C. and/or its physicians and to exercise any appeals and other rights under my policy or benefits plan on my behalf.

I authorize and assign to Coastal Spine, P.C. and its physicians the right to file suit and to obtain counsel and enter into legal or other actions on my behalf and/or in my name, including arbitration/dispute resolution processes, for any claims against my insurance carrier, PIP carrier, Workers' Compensation carrier, plan administrator, payor or third party.

I authorize Coastal Spine, P.C. and/or its physicians to appoint an attorney to represent me directly for the collection of PIP benefits, Workers' Compensation benefits and all other insurance benefits through the carriers themselves, plan administrator, payor or third party. I authorize Coastal Spine, P.C. and/or its physicians to obtain an attorney to represent me directly in appealing a claim to the appropriate state or Federal Agency for all state and federal plans.

I authorize Coastal Spine, P.C. and/or the physicians to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

I direct my insurance carrier, or its intermediaries, to issue a payment check directly to Coastal Spine, P.C..

If my insurance carrier will not directly pay Coastal Spine, P.C. and/or its physicians, I authorize and direct the insurance company to send all checks and copies of Explanation of Benefit forms in connection with the services of onset date of service to present to my home address and/or the billing company and/or the attorney representing Coastal Spine, P.C. and/or the physicians so that we may forward checks to Coastal Spine, P.C., 4000 Church Rd, Mt Laurel, NJ 08054. All such checks must be made out to me and Coastal Spine, P.C. jointly.

If my insurance carrier requires a referral prior to commencement of treatment, I agree to obtain this prior to any examination or treatments.

Financial Responsibility

I understand that I am responsible for co-payments, deductible payments, and other charges not covered by my health care benefits. It is my responsibility to notify Coastal Spine, P.C. of any changes in my health care coverage. I am responsible for the entire bill or balance of the bill as determined by Coastal Spine, P.C. of the health insurance company if the submitted claims or any part of them are denied for payment.

In the event that I receive direct payment from my carriers or benefits plan of any amounts due to Coastal Spine, P.C. and/or its physicians for services rendered, I agree to forward immediately to Coastal Spine, P.C. any checks made payable to me. I agree to notify Coastal Spine, P.C. upon receipt of such check and to endorse the checks appropriately "Pay to the Order of Coastal Spine, P.C.." and immediately mail the check and any Explanation of Benefits to Coastal Spine, P.C., 4000 Church Rd, Mt Laurel, NJ 08054, keeping copies of the check and Explanation of Benefits for my record.

I have read and understand the terms and conditions of the ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY outlined above and accept full responsibility for this account. I understand my signature below creates a valid contract between the patient and the provider.

PRINTED PATIENT NAME: ______________________________________

AUTHORIZED SIGNATURE: _____________________________________ DATE: ___________________________

WITNESS: ____

NAME OF PERSON PROVIDING AUTHORIZATION (if different from patient): ___________________________________