

Authorization for Direct Payment

Before Mohn Back & Neck Care Center can extend a patient credit, the patient must provide us with proof of automobile insurance coverage. If multiple sources of coverage exist, this office will submit directly to all insurance companies, (except third party insurance) to ensure 100% reimbursement of your account to Mohn Back & Neck Care Center while you are receiving care. Overpayments are refunded to the appropriate party when patients are released from care. Third party billing is done at the patient's request and arrangements must be made in advance. A patient's account is charged any time this office is required to produce copies of medical records or complete and mail any medical reports.

As a means of appropriating payments due this office expeditiously, patient's selecting this payment option give Mohn Back & Neck Care Center permission to endorse their name to checks payable to both parties, by way of a limited power of attorney.

_____ I do hereby authorize Mohn Back & Neck Care Center to furnish you, the insurance company, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

_____ I hereby authorize and direct all insurance companies, attorneys, etc., to pay directly to Mohn Back & Neck Care Center, such sums as may be due and owing Mohn Back & Neck Care Center, from all monies received which are intended, in whole or part, as payment, reimbursement, or compensation for medical services rendered. If assignment is prohibited, I am requesting that the amount due in payments or at the time of settlement be released as payment to the order of myself AND Mohn Back & Neck Care Center. Said payments are to be mailed to Mohn Back & Neck Care Center at 4341 Route 60 East, #177 EHSC, Huntington, WV 25705.

_____ I fully understand that I am directly and fully responsible to Mohn Back & Neck Care Center for all medical bills submitted by Mohn Back & Neck Care Center for services rendered me and that this agreement is made solely for Mohn Back & Neck Care Center's additional protection and in consideration for the doctor's awaiting payment. Finally, I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Patient/Authorized Signature

Date