

**Vancouver Spine & Orthopedic Rehabilitation Center, PLLC**  
**11802 NE 65<sup>th</sup> Street, Suite 100**  
**Vancouver, WA 98662**

**PATIENT FINANCIAL RESPONSIBILITY AGREEMENT**

Thank you for allowing Vancouver Spine to assist you with your care. As a courtesy to you we will bill your insurance. If there are any changes in your insurance, please let us know immediately so we can submit your claim properly.

**Co-Pays are due at the time of service. You will begin receiving monthly statements with any balances after your insurance company has been billed.**

**If You Have Insurance:**

Our office will cooperate in processing your insurance claim and will wait for payment by your insurance company. If your insurance company does not pay within 60 days from the date of treatment, or does not pay the balance due, you will be held responsible to pay the office directly.

**Accident Cases:**

If you are injured by someone else, and have no insurance to cover your bill, our office may cooperate with you in processing your claim against the person who injured you. We may agree to wait for payment of your bill from the proceeds of any settlement or judgment. However, you are still responsible for full payment whether or not you collect from the other party, or their insurance. If we do agree to wait, you and or your attorney must cooperate with the clinic and sign an assignment of the insurance or settlement proceeds, so payment will be made directly to Vancouver Spine. A lien may also be filed for any case that does not involve an attorney.

**Injuries at Work:**

If you have been injured while on the job and your injury has been accepted. Vancouver Spine will bill workman's compensation carrier and no payment will be required. However, if your case has been denied it will be your responsibility to pay your bill in full.

**Authorization to Release Information:**

You give Vancouver Spine & Orthopedic Rehabilitation Center, PLLC permission to release information about your physical condition to your insurance company, primary care physician or attorney in order to process your bills for payment. You also authorize payment of medical benefits directly to our office for any treatment billed by us to your insurance company.

**\*There will be a \$ 35.00 fee for NSF checks (non-sufficient funds).**

PRINT PATIENT NAME: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT/GUARDIAN must sign if patient is under 18 years of age

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_