FINANCIAL AGREEMENT

Name:________________________ Date:____________

Total = ______ Paid on = <u>1st</u> <u>15th</u> Amount Per Month = ______ Number of Months = ______

Card Holder Name___________________________ Phone ________________ Zip Code__________

❑ Visa ❑ MC Card # ____________________________ Exp:_____/_____ CV Code_______

PATIENT INSURANCE APART OF ANY FEDERALLY FUNDED PROGRAM OR AID YES NO

Patient acknowledgment: ____

Date: ________________________

By signing below I fully understand the doctor's recommendations and understand the financial obligation of co-pay and deductible (*if any*), in addition charges for services will be billed directly to my insurance company. Some patients might receive the physical check at their residence and are responsible for turning over to Pain and Wellness of Arizona for services rendered.

NOTE: PATIENT RESPONSIBLE FOR REPORTING CHANGES IMMEDIATELY OF INSURANCE AND CAN BE HELD FINANCIALLY LIABLE.

Patient's acknowledgment: ____

Date: ________________________

Special Arrangements:

Patient's acknowledgment: ____

Date: ________________________

By signing here I am stating that my financial responsibility for the co-insurance (or my co-pay) and the deductible would be a financial hardship for me at this time. I understand that Pain and Wellness of Arizona is relieving me of, or assisting me with this financial burden so that I can receive the agreed upon course of care, <u>on the condition that I complete my treatment plan</u>.

Financial Interest of Entities

In compliance with the requirements of law R4-7-902.1, you are hereby advised that John Eby and Jeff Jennings has a direct financial interest in Pain and Wellness of Arizona. Further, patient understands that this is a medical office run by a Medical Director, MD/DO, and that the treatment protocol of this center includes multiple services including therapeutic injections, chiropractic, physiotherapy, x-ray & ultra sound. All services we recommend are available elsewhere on a competitive basis.

We ask that you acknowledge your having read and understood the disclosures contained in this Notice by signing and dating this form in the spaces provided below. We will keep the signed original in your patient file.

Patient's acknowledgment: ____

Date: ________________________

Interventional Pain Management Services Agreement

This is an agreement for a consultation and services provided by Pain & Wellness of Arizona. Interventional pain management services are provided at PWAZ under the direction of allopathic and or osteopathic physicians, including: prescription medication, neuromuscular integration, physiotherapy, massage therapy, exercise therapy, muscle strength training, osteopathic medicine, homeopathic medicine, orthomolecular nutrition, trigger point injections, and joint injections; with the sole exception of chiropractic manipulation, which is provided under the direction of a chiropractor. A PWAZ physician will recommend and or prescribe one or more of the above services if it is found that it is medically necessary for the treatment of your condition.

Only physicians can make a recommendation or referral for you to receive a specific medical service or modality. In the event that a non-physician medical provider, including an overly enthusiastic member of our staff recommends that you receive a specific medical service or modality, please notify one of our physicians or physician assistants immediately for an impartial medical review, independent medical exam, and original consultation. This way, we can review and update the medical necessity of your treatment plan to make sure that you get the best medical care possible.

I hereby agree to the above terms and conditions and wish to receive interventional pain management services at PWAZ.

____ ______________________

Patient or Authorized Representative *Date*