NOTIFICATION TO OUR PATIENTS

Our staff will call your insurance company to verify coverage and obtain authorization for your procedure.

If you have a deductible that has not been met, our billing staff will do their best to contact you in advance for a payment prior to your procedure for the physician's services. Physician services are separate from the surgical suite and the pathologist charges.

Please understand that there are four components to your services:

- Physician's services, including laboratory testing, if any _____ initials
- Surgical suite services (facility) _____ initials
- Anesthesia services _____ initials

I have read and understand the above.

_____

SIGNATURE OF PATIENT DATE

MEDICARE BENEFIT ASSIGNMENT

I request that payment of authorized MEDICARE BENEFITS be made to TARA M. SHERIDAN, M.D.

_____

SIGNATURE OF PATIENT DATE

RIVERSIDE COUNTY
31469 Rancho Pueblo Rd., Temecula, CA 92592
Phone: 951.303.3718
Fax: 951.303.0451

www.UnitedPainCenter.com

UNITED
PAIN CENTER

AUTHORIZATION TO RELEASE INFORMATION

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. (If other health insurance coverage is indicated in ITEM 9 of the HCFA 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown.)

FINANCIAL RESPONSIBILITY

On occasion your insurance may determine the care you have received is NOT a covered benefit. Please read your insurance handbook and be aware of what your insurance offers for benefits. When in doubt contact your insurance company directly for clarification. You will be responsible for care not covered by your insurance plan.

- Not a covered benefit - is not covered or only partially covered by your insurance plan, also excluded may be work injury or auto accidents.
- Not deemed medically necessary - not provided as the result of illness or injury.
- Before or after eligibility - services provided during a period your policy is not in effect.

SIGNATURE OF PATIENT DATE

I HAVE READ THE ABOVE INFORMATION AND I UNDERSTAND MY FINANCIAL OBLIGATION TO DR. SHERIDAN AND UNITED PAIN CENTER, TEMECULA.

SIGNATURE OF PATIENT DATE WITNESS DATE

RIVERSIDE COUNTY
31469 Rancho Pueblo Rd., Temecula, CA 92592
Phone: 951.303.3718
Fax: 951.303.0451

www.UnitedPainCenter.com