LIFETIME INSURANCE ASSIGNMENT AND AUTHORIZATION FORM

Clearway Pain Solutions Institute is pleased to file insurance for our patients. In order to correctly process your insurance claims, the patient or responsible party is responsible for providing, at the time of service, the most current address, phone number and insurance information.

Lifetime Insurance Assignment

I hereby instruct and direct my past and/or present insurance company to issue payment directly to:

Clearway Pain Solutions Institute
4901 Marketplace Road
Pensacola, Florida 32504

for all medical, surgical, and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered. This payment will not exceed my indebtedness to Clearway Pain Solutions Institute and I agree to pay, within sixty (60) days of the date of the first monthly bill, any balance of said charges over and above this insurance payment, including applicable copayments, deductible, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is limited by agreement or law to Clearway Pain Solutions Institute. A photocopy of this assignment shall be considered as effective and as valid as the original. Furthermore, I understand that 1) Clearway Pain Solutions Institute accepts Medicare assignment and Medicare payments will be directed to Clearway Pain Solutions Institute and 2) Clearway Pain Solutions Institute does not accept responsibility for collecting insurance or negotiating a settlement of a disputed insurance claim and any accounts balance not pain in full within sixty (60) days of the date of the first bill is considered delinquent. I agree to pay reasonable attorney's fees and collection expenses should my account be referred for collection procedures.

Authorization to Use and Disclose My Protected Health Information

I authorize Clearway Pain Solutions Institute to use or disclose information about me for the following reasons:

TREATMENT: Clearway Pain Solutions Institute may disclose information about me to my primary care physician, referring physician, and other individuals consulted by my physician so that those involved in my treatment can manage my healthcare needs. If applicable, I expressly consent to the use and disclosure of information regarding testing and/or treatment for HIV/AIDS, substance abuse, mental health, sexually transmissible, and genetic conditions to such consultants and/or other healthcare personnel that may be involved in my care.

PAYMENT: Clearway Pain Solutions Institute may use and disclose information about me to any person or corporation which is or may be liable for all or any portion of the charges incurred in connection with these services, including insurance companies, health care service plans, works compensation carriers, adjusters or attorneys, to the extent necessary to obtain reimbursement. If applicable, I expressly consent to the use and disclosure of information regarding testing and/or treatment for HIV/AIDS, substance abuse, mental health, sexually transmissible, and genetic conditions to any third party payors that may be responsible, in whole or in part, for payment on my behalf.

OPERATIONS: Clearway Pain Solutions Institute may use and disclose information about me as needed to support its business activities. Examples of business activities may include notification of pharmaceutical and medical device recalls, communication about health-related products or services provided by Clearway Pain Solutions Institute, and quality improvement activities designed to assess and improve the quality and effectiveness of the healthcare and services Clearway Pain Solutions Institute provides to its patients. If applicable, I expressly consent to the use and disclosure of information regarding testing and/or treatment for HIV/AIDS, substance abuse, mental health, sexually transmissible, and genetic conditions to support its business activities.

I further agree and acknowledge that:

- My health information is stored in an Electronic Medical Record (EMR) that is shared by Clearway Pain Solutions Institute health care professionals.
- I have the right to request that you restrict how information about me is used or disclosed for treatment, payment, or operations. I understand that you are not required to agree to these restrictions, but if you do agree, you are bound by the restrictions.
- Should I decline to sign this Lifetime Insurance Agreement and Authorization Form, I assume full responsibility for all charges incurred for services provided at Clearway Pain Solutions Institute and that these charges are due in full at the time of the service.

This Lifetime Insurance Assignment and Authorization is ongoing and will not expire until such time as written notice of revocation is provided.

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Patient Signature or Legal Representative	Patient DOB	Date