

**FINANCIAL AGREEMENT BETWEEN PATIENT &
SOUTHWEST OHIO PAIN MANAGEMENT/DESERT VALLEY PHYSICIANS**

The facility, Southwest Ohio Pain Management/Desert Valley Physicians, where your procedure(s) is/are being performed, as well as the provider performing your procedure is a non-network provider for most insurance companies.

Some insurance companies, such as Blue Cross Blue Shield and United Healthcare, have chosen not to honor their insured's assignment of benefits to non-network providers. This means these insurance companies may not send payment or explanations of benefits directly to this office, but instead will send these items to you.

By signing this agreement you acknowledge and agree it is your responsibility to bring to our facility any payment from your insurance company for services rendered by our facility or physicians immediately. Furthermore, you agree not to deposit or cash these funds, but instead endorse them over to our office when you bring it in. _____ (please initial)

Depositing or cashing funds sent directly to you for services rendered by our Facility or Physicians would represent a violation of this agreement, as well as failing to present to our office within 30 days of issue the endorsed checks received for payment of our services.

If you violate this agreement, you will be held responsible for the full balance of your accounts, which may be much more than the amount paid by your insurance company. You also agree to pay any legal or collection fees incurred by Southwest Ohio Pain Management/Desert Valley Physicians in the process of collecting outstanding balances on your account. You also agree that we may process your attached credit card to pay any outstanding balance if you violate this agreement.

Printed Name of Patient: _____

Signature of Patient: _____

Signature of authorized representative for Southwest Ohio Pain Management/Desert Valley Physicians