Neurosurgery
Kurt Eichholz, MD, FACS
Peter Sylvester, MD, MHA

Orthopedic Surgery
Robert A. Morgan, MD, FACS

Release of Information, Assignment of Benefits and Financial Responsibility

Patient's Name:_______________________________________
Insured's Name:_______________________________________

Release of Information: I authorize the release of medical and financial information for the purpose of collection of my account. I also authorize my insurance benefits to be paid directly to Kurt M. Eichholz, MD/St. Louis Minimally Invasive Spine Center, LLC and acknowledge that I am financially responsible for any unpaid balance. I agree to pay this balance in full, and if unable to pay in full, will make other arrangements with the office.

Insured Agreement: I am aware that my insurance carrier may require me to use participating providers and to follow plan requirements, including primary care referral if applicable. Further, I agree to contact my insurance company about all outpatient procedures and/or diagnostic imaging, to assure that any required surgical second opinions and precertifications are completed prior to the procedure. I also agree that failure to comply could result in my sole responsibility to pay any charges for services rendered.

Self-Pay Agreement: If I do not have any insurance coverage, or if my insurance carrier does not cover this service, I agree to be responsible for the full balance. If I am unable to pay the balance in full, I agree to make other arrangements with the office. I understand St. Louis Minimally Invasive Spine Center, LLC charges $30.00 for any checks which are returned for insufficient funds. I also understand that if I default in payment of my account that I will be responsible for all collection fees and/or attorney fees and court costs.

Test Results: I understand it is my responsibility to contact the office of Kurt M. Eichholz, MD for all test results.

_______________________________________ ____________________
Signature of Patient (if minor, legal guardian) Date

Receipt of Notice of Privacy Practices

I have received a copy of St. Louis Minimally Invasive Spine Center's Notice of Privacy Practices dated 4/01/13.

_______________________________________ ____________________
Signature of Patient (if minor, legal guardian) Date