Brian Siegel, MD
Advanced pain relief to enhance your life

ASSIGNMENT OF INSURANCE BENEFITS/RESPONSIBILITY

STATEMENT (for insured patients): I hereby authorize my insurance company or other authorized agency to make payment of benefits otherwise due me for services provided by Dr. Brian Siegel M.D. during this period of clinical service directly to **Brian Siegel, M.D.** For value received, I, the undersigned, herby acknowledge, represent and agree that **I am responsible for the payment of any and all amounts my insurance company or authorized agency denies, contests, or otherwise leaves unpaid**, whether claimed or not claimed by me or Dr. Brian Siegel and I hereby agree to pay, or course same to be paid in full within forty five (45) days after the dates of the service rendered. In the event it shall be necessary for Dr. Brian Siegel to refer such a bill to an attorney for collection, I hereby agree to pay the cost incurred in pursing such action including reasonable attorney fees.

I HEREBY AUTHORIZE Dr. Brian Siegel to release to his billing company and the insurance companies named on my account or their utilization review organization, any and all such information as my be necessary for the completion of my claims for medical benefits of any kind.

RESPONSIBILITY STATEMENT (for self-pay patients): For value received, I, undersigned hereby acknowledge, represent and agree that I am responsible for the payment of all charges and costs incurred by me for services provided by Dr. Brian Siegel and I hereby agree to pay same in full prior to my appointment or to pay, or to cause same to be paid in full, within not more than thirty (30) days after the date of services rendered. In the event it shall be necessary for Dr. Brian Siegel to refer such a bill to an attorney for collection, I hereby agree to pay the costs incurred in pursuing such action, including reasonable attorney's fees.

_____ Date _____
Signature of Patient/Guarantor

_____ Date _____
Signature of Representative/Witness

Pain Management Clinic **940 Central Park Drive, Suite 202** **Steamboat Springs, CO 80487** **Tel 970-871-2363/Fax 970-871-2363**	**Patient ID**