ShimSpine

John H. Shim, M.D.

Patient Name:_____

AUTO INSURANCE BILLING POLICY

I authorize my insurance carrier, attorney or other appropriate party to pay directly to ShimSpine / Florida Sports Orthopaedic & Spine Medicine any and all medical or surgical expenses payable under the terms of my insurance contract or any legal settlement. In making this assignment, I also agree that any balance not covered by my insurance carrier or legal settlement for any reason will be paid by me in full.

It is our practice policy to bill your auto carrier for services rendered until such time that benefits are exhausted. Once your auto benefits have been exhausted you will be required to pay any outstanding billed charges at the time of service or in the event that you have retained an attorney to represent you, we will ask you to sign a Private Financial Contract which will serve as a letter of protection against the proceeds from any settlement or verdict related to your injury claim.

You are responsible for any outstanding balance not paid by your auto carrier including but not limited to deductibles and co-insurance. This balance is due at the time of service and will be collected prior to your scheduled appointment.

I understand and agree that I am responsible for any cost incurred for legal or collection fees necessary to satisfy my financial obligation to ShimSpine / Florida Sports Orthopaedic & Spine Medicine including reasonable attorney fees, court costs, or collection expenses.

I understand and agree that photocopies of this form will be valid.

_____

Signature of Patient or Responsible Party **Date**

_____

Physician (or authorized agent)

309 State Street East Suite 201 Oldsmar FL 34677 ▪ (813) 814-9251 ▪ Fax: (813) 814-9261
Shimspine.com