PAYMENT OF BENEFITS

I understand that payment for my Medical Services rendered by Elias Dagnew, MD is my responsibility regardless of insurance coverage. I hereby assign all payments to which I am entitled for medical expenses related to the services rendered by Elias Dagnew, MD / Viren Vasudeva, MD or other physicians affiliated with the practice to **Georgia Brain & Spine Center, PC**. **I authorize Georgia Brain & Spine Center, PC** to release any medical information to my insurance carrier or third-party payer to facilitate processing of my insurance claims. I understand that failure to pay outstanding balances within 90 days of the statement will result in an additional 15% finance charge and/or submission to an outside collections agency. A $35.00 returned check fee will be charged for checks returned due to insufficient funds.

_____ _____

Signature of Patient/Guardian Date