Consent for Workers' Comp Assignment of Benefits

Acct #:____________ Date:____________
CORE Provider:____________________
For office use only

Patient Name: ________________________________ Date of Birth: ________________

Initials

_________ I assign to The CORE Institute®, (the "Company") the right to receive payment for all health care services rendered to me under my worker's compensation coverage.

_________ I understand and agree that I will aide, and assist the Company in procuring payment for all health care services rendered to me by my worker's compensation coverage including providing any and all information or documentation required by the Company, my employer, or my employer's worker's compensation insurance coverage and I further understand that failure to do so my result in my worker's compensation claim being denied.

_________ I understand that the Company will bill my employer's worker's compensation coverage directly under provisions and stipulations of the current Arizona Industrial Commission or Federal Worker's Compensation Fee Schedules.

_________ I understand and agree that the Company will make very reasonable effort to acquire appropriate authorization for health care services rendered by the Company to me required by my employer's worker's compensation insurance coverage.

_________ I understand and agree that I will not be billed directly for health care services rendered unless my worker's compensation claim, or authorization of health care services rendered is denied.

_________ I understand and agree that I am responsible for providing the Company with a current mailing address where I will receive U.S. Mail.

_________ I understand and agree that in the event that my worker's compensation claim and/or authorization for health care services under such a claim is denied that I will be billed directly for all health care services rendered to me by the Company and that I will pay for any and all health care services in full when billed.

_________ I understand and agree that in the event that Company is required to enter into collections proceedings against me personally for payment of health care services rendered that a 60% collection fee will be charged, as this is the fee required for the Company to recover collection costs.

_________ I state by my signature below that I have read, understand, and agree to the stipulations set forth in this agreement and agree to proceed with care as an informed consumer.

Patient Signature: ________________________________ Date: ________________

Witness Signature: ________________________________ Date: ________________

© The CORE Institute. All rights reserved.