HANOWELL SPINE CLINIC
ARTHRITIS & OSTEOPOROSIS CENTER
4142 MILL ST. NE
COVINGTON, GA 30014
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ALISON S. HANOWELL M.D. M. DALTON HANOWELL M.D. KAYLIN G. SPELL NP-C

Payment Waiver/Consent and Agreement to Pay Form

I, _____ understand that by signing this waiver, I am agreeing to pay for any non-covered services provided by the physicians and practitioners of Hanowell Spine Clinic and Hanowell Pain Management.

Our primary concern as your physicians is to provide you with the best possible care. Follow up visits and treatments are scheduled with the purpose of providing that care and patients are not asked to return more often than is medically necessary.

Recent changes in insurance regulations have limited the number and type of procedures that insurance will allow for certain problems even though these procedures may be needed to properly treat your condition(s). Some insurance companies consider these procedures "medically unnecessary", consequently refusing to pay for them.

Since we believe each scheduled visit in our office is medically necessary, every effort will be made to collect payment from your insurance company. In the event that payment is denied, you will be responsible for paying for these services. Insurance regulations require that you read and sign the agreement below:

I (the patient) have been informed that payment for the services rendered today may be denied if my insurance considers these services to be "unreasonable and or medically unnecessary". Since both the doctor and I consider these services necessary for the proper treatment of my condition(s), I agree to be responsible for the allowed amount of the charges or a remaining balance after my insurance has paid in full.

I have read, understand and have a copy of the Waiver/Consent and Agreement to Pay Form and accept all terms listed above.

Patient's Signature:_____Date:_____

Legal Guardian Signature:_____Date:_____

Witness Signature:_____Date:_____