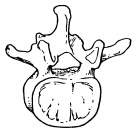
S O U T H T E X A S
SPINAL CLINIC, P.A.



FINANCIAL DISCLOSURE

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I _____ understand that the office staff of the South Texas Spinal Clinic, has verified my benefits and to the best of everyone's understanding my insurance carrier covers the procedures performed by the medical staff. As stated by my insurance carrier they are only a verification of benefits and are not a guarantee of payment. If there are any services which are not covered under my plan due to plan provisions within my policy they will be my responsibility. It is also understood that it is ultimately my responsibility to contact my insurance carrier if I have a questions regarding my plan provisions. Due to these provisions I might be liable for a deductible, co-pay and co-insurance depending upon my plan provisions. It is also understood that if there is a change within my insurance carrier, I will notify the South Texas Spinal Clinic office to update my file before my next visit. If I fail to do this I may be responsible for the full fee. When I receive my statement from the South Texas Spinal Clinic billing office I will make arrangements to pay my balance in full within 30 days. If I cannot pay my balance in full I will contact the South Texas Spinal Clinic collections department to make suitable payment arrangements.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Acct # _____

Medical Rec. #_____

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