



Michael Moon, M.D. • Timothy Yoon, M.D.

FINANCIAL RESPONSIBILITY

I the patient, accept financial responsibility for all charges incurred. In the event my insurance pays me directly for services rendered, I promise to immediately sign over and forward those payments to PainCare.

I also understand that there is a missed/ cancellation appointment policy and I will be responsible for any charges incurred under this policy.

AUTHORIZATION: I hereby authorize payment directly to PainCare of San Diego for medical services rendered and to release any information acquired in the course of my examination or treatment to my insurance company for payment.

Print Name

Signature

Date