



JACKSONVILLE
PAIN CENTER

.....Center for excellent care

Insurance information consent

I certify that the insurance information I have given to the Jacksonville Pain Center and Dr. Hemant Shah is current. I understand that if there are any changes in my insurance, I must notify Jacksonville Pain Center and Dr. Hemant Shah immediately. If I fail to notify as mentioned above, I accept responsibility for any charges incurred for non-authorization or non-covered services.

Patient Signature

Date