Patient Authorization Form

Business Office 8555 16th Street, Suite 310 · Silver Spring, Maryland 20910
Tel 301-562-7200 · FAX 301-565-6772

THE NEUROLOGY CENTER

HIPAA Privacy Acknowledgment:
I hereby acknowledge the receipt of The Neurology Center's Notice of Privacy Practices.

Initials: _____

Date:_____

I do hereby authorize The Neurology Center, P.A. to apply for benefits on my behalf for covered services rendered. I request that payment from Blue Cross/Blue Shield of the National Capital Area and/or my insurance carrier be made directly to you (or, in the case of Medicare Part B benefits, to myself or to the party who accepts assignment).

I do hereby authorize and direct my personal injury protection insurance carrier/automobile insurance to make check(s) payable to The Neurology Center any monies due them for medical services provided to me as a result of a personal injury.

I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier and/or to Blue Cross/Blue Shield of the National Capital Area (or, in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration). I permit a copy of this authorization to be used in place of the original.

MANAGED CARE and HMOs:
I certify that the information I have reported with regard to my insurance coverage is correct. I understand that my insurance plan requires that I submit a referral for specialty care services, and I am responsible for obtaining that referral. **I am aware that if I fail to submit my referral, I will be responsible for full payment.** _____(Initial)

OUT OF PLAN/OPEN ACCESS
I am choosing to go Out-of-Plan or use my OPEN ACCESS benefits without a referral for date of service_____. **I am aware that I may be responsible for additional out-of-pocket expenses based on my benefits.** _____(sign)

It is further understood that the signing of this form in no way relieves me of my personal primary obligation to pay for services rendered and does not prohibit customary billing by The Neurology Center.

_____ _____

DATE SIGNATURE

_____ _____

WITNESS PRINTED NAME OF SUBSCRIBER

ACCIDENT RELATED SERVICES
I DO NOT authorize The Neurology Center to apply for benefits under my health insurance plan. This releases The Neurology Center from any contractual obligation with my health insurance carrier. I understand that I am personally responsible for payment in full for services received.

_____ _____

DATE SIGNATURE