Patient Authorization Form

Business Office 8555 16th Street, Suite 310 · Silver Spring, Maryland 20910
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THE NEUROLOGY CENTER

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

Initials: _____
Date: _____

I hereby authorize The Neurology Center, P.A. to file claims on my behalf for covered services rendered. I request that payment from my insurance carrier be made directly to you.

I further authorize The Neurology Center, P.A. to electronically access my medication history from my pharmacies for review and inclusion in my electronic medical record.

I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier.

In order for the practice to continue to offer services to patients, it is our expectation that all patients will pay the patient portion of their balances in full at the time of service. We realize that sometimes a patient may not be able to pay the full amount therefore we offer flexible options. If you are unable to pay your personal balance, please see someone in our office for assistance.

Please be advised that the practice considers balances that are older than 60 days as delinquent. It is our policy to place delinquent accounts with an outside collection agency. If that becomes necessary, the practice reserves the right to charge the patient and/or guarantor a collection fee equal to 40% of the outstanding balance which is the amount that is charged by the collection agency for their services.

HMO Policy for Referrals to Specialists:
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.** _____(Initials)

Out of Plan/Open Access
I am choosing to go Out-of-Plan or use my Open Access benefits without a referral. **I am aware that I may be responsible for additional out-of-pocket expenses based on my benefits.** _____(Initials)

Accident Related Services:
We bill PIP insurance up to the limits of your coverage, after which we will then bill your health insurance. Under NO circumstances will we accept an Authorization and Assignment (A&A) from any attorney's office, nor will we bill any third party PIP insurance carrier.

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 PATIENT