

NEUROLOGY & NEUROSCIENCE ASSOCIATES, INC.

701 White Pond Drive, Suite 300, Akron, OH 44320 (330) 572-1011 ~ fax (330) 572-1018

Patient Name: _____

Date of Birth: _____

PLEASE READ AND SIGN BELOW

- I hereby give my consent for the Physicians and Staff of NEUROLOGY & NEUROSCIENCE ASSOCIATES, INC. to examine and render medical treatment and care to the above named patient, including the performance of those diagnostic and therapeutic procedures deemed advisable.
- In consideration of any medical care provided to the above named patient, I assign to NEUROLOGY & NEUROSCIENCE ASSOCIATES, INC. all my rights to any and all medical insurance benefits to which I am, or may be entitled to by any public or private payor.
- I understand that I will be fully responsible for payment of any and all charges not covered by my medical insurance at the current rates established by NEUROLOGY & NEUROSCIENCE ASSOCIATES, INC. for all services rendered to the above named patient.
- I hereby authorize NEUROLOGY & NEUROSCIENCE ASSOCIATES, INC. to disclose to employer groups, insurance companies, government agencies, or other third party payors and their agents or to utilization management companies, information in the form of verbal conversations, copies of the patient medical record, and/or other documents concerning medical care or treatment that may be necessary for the payment, on my behalf, for services rendered to the above named patient, which may include retrieval of my credit history.
- I hereby authorize NEUROLOGY & NEUROSCIENCE ASSOCIATES, INC. to disclose individually identifiable health information created or received by NEUROLOGY & NEUROSCIENCE ASSOCIATES, INC. whether oral or recorded in any form of medium, regarding the above named patient to any health plans that may be responsible for providing or paying the cost of rendered services in order to carry out payment activities.
- I further authorize NEUROLOGY & NEUROSCIENCE ASSOCIATES, INC. to disclose such health information to contractors or other persons who carry out, assist in the performance of, or perform functions or activities for, NEUROLOGY & NEUROSCIENCE ASSOCIATES, INC. Including legal, auditing, consulting, data processing, billing and coding services, and services related to health care operations, provided that such persons have provided assurances that the information will be appropriately safeguarded.
- This authorization may be revoked in writing at any time except to the extent that actions have been taken in reliance thereon.

Signed: _____
Patient or Responsible Party

Date: _____

Office Use Only

Account # _____