Neurology Partners, P.A., dba Emas Spine and Brain Specialists
Medical Consent and Financial Form
Including all Accident-Related Visits

Our relationship with you is based on rendering the best possible care and a clear understanding of our financial policies.

Please be advised that your insurance coverage is a contract between you, your employer, and the insurance company. Neurology Partners, P.A. is not a party to this contract. Our professional services are rendered to you, not the insurance company therefore payment for services is your responsibility.

If you have a referral based HMO/PPO/POS insurance plan, **IT IS YOUR RESPONSIBILITY TO HAVE A VALID REFERRAL UPON EACH VISIT.** Not all services are a covered benefit in all contracts; therefore if your insurance does not pay for a service you will be responsible for payment in full.

It is your responsibility to know and understand your plan benefits. Your deductible and/or copay are due at time of service. **WE ARE CONTRACTUALLY OBLIGATED BY INSURANCE CONTRACTS TO COLLECT YOUR DEDUCTIBLES AND COPAYS AT THE TIME OF YOUR VISIT.**

It is your responsibility to provide us with your current insurance card and to notify us of any changes with your insurance. We cannot be responsible for filing claims to the wrong insurance companies if the incorrect insurance card was provided to us. We do not file your Health Insurance until your Personal Injury Protection (PIP) benefits are exhausted. If we do not participate with your insurance, we will file your insurance only as a courtesy.

Self-pay patients: Payment in full is required at the time services are rendered unless prior arrangements have been made with the billing office.

Patient balances are billed monthly and you are responsible for timely payment of the balance. We accept cash, check, money order, Visa, and Mastercard. All returned checks are subjected to a $50.00 return check fee. Patient account balances older than 60 days are subject to collection procedures. We realize that temporary financial problems may affect timely payment on your account. If such problems arise we request that you contact our billing office at (904) 448-4180 to make payment arrangements. If you have any questions, contact our office, we are happy to help. If after 60 days we are required to obtain legal representation to enforce collection of any unpaid amount(s) against you, you hereby agree to pay for all costs of collection, including the payment of reasonable attorney fees.

CANCELLATION / NO SHOW POLICY

Failure to cancel your appointment 48 hours prior to your appointment or failure to show for your appointment will result in a $50.00 cancellation fee**. This fee is NOT covered by your insurance carrier. You will be personally responsible for this fee.**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY AT NEUROLOGY PARTNERS, P.A.

NOTICE OF PRIVACY is available for your review. It is located in our waiting room. You may also request a copy of it for your personal needs.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby instruct and direct any insurance carrier that is providing insurance benefits on my behalf under any policy of insurance to make out a check to, and directly pay, Neurology Partners, P.A., for professional medical and rehabilitative services rendered to me. This is a direct assignment of my rights and benefits under any such policy of insurance and may only be revoked with express written consent of Neurology Partners, P.A. This assignment of insurance benefits is given in consideration of all professional services, including past services provided by Neurology Partners, P.A., in relation to such illness/accident.

This assignment of insurance benefits is provided so that Neurology Partners, P.A. may obtain my payout history from the insurance carrier, and attempt to collect any unpaid and over-due insurance benefits directly from the insurance carrier. This includes the assignment of any cause of action that might accrue against my insurance carrier for its failure to pay insurance proceeds.

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION

I authorize Neurology Partners, P.A. to release all medical information (including, but not limited to information relating to psychiatric evaluation and treatment, sickle cell anemia, alcohol, and drug abuse diagnosis and treatment, HIV status, AIDS or AIDS related diagnosis, if any such information exists) to all my insurance carriers or other third party payers as may be required or requested for the processing of claims or other insurance purposes.

ACKNOWLEDGEMENT

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES. I AUTHORIZE THE ASSIGNMENT OF BENEFITS AND RELEASE/ RECEIPT OF INFORMATION.

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Patient Signature D.O.B. Date