HOPE Neurology

Authorization Form

Assumption of Responsibility Initial_____

- I agree that in consideration of provided services, I assume financial responsibility and agree to pay PROVIDER all charges for services incurred.
- If referred for collections, I agree to pay reasonable attorney fees and collections expenses.
- Even though Insurance may be filed, I understand that all bills are payable upon receipt and that I, and not the insurance company, am responsible for payment of all services.

Responsibility for Co-Payments Initial_____

- I agree to be fully responsible for paying any co-payments on the date of service.
- I understand that if my co-payment is a percentage, I am responsible for payment following co-insurance payments from my insurance carrier.

Assumption of Referrals Initial_____

- I understand that if my insurance requires a referral from a primary care physician, the referral must be received at Hope Neurology prior to treatment in order to receive maximum benefit from my insurance carrier.
- I further understand that it is my personal responsibility to obtain a hardcopy of the referral from my primary care provider.
- I have been given the opportunity to obtain a referral or re-schedule my appointment. By refusing to obtain a referral, I understand and take responsibility for full payment of provided services.

Assignment of Insurance Benefits Initial_____

- I assign and authorize payment my insurance benefits to be paid directly to the physician until account is paid in full.

Acknowledgment of Receipt of Privacy Notice Initial_____

- I acknowledge receiving a copy of the PROVIDER's notice of privacy policies.
- I consent to the PROVIDERS's use of protected health information as described in the notice for treatment, payment, or health care options.
- I understand that I must provide a separate authorization before any other disclosures may be made.

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Signature Date