Neurosurgical Specialist of North Florida

AUTHORIZATION

Patient and/ or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance, however you are responsible for your co-pay and/ or percentage which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days, you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/ or guarantor, we will place your account with a collection agency which will leave you liable for additional expenses incurred if applicable. I_____have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physicians, physician assistants and nurse practitioners and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

_____ _____

Signature Date

_____ _____

Witness Date

I request that payment of authorized Medigap (Medicare supplement) benefits be made on my behalf to the provider for any services furnished to me by that provider. I authorize any holder of medical information about me to release to Medigap Insurer _____ any information needed to determine these benefits payable for related services.

_____ _____

Signature Date

MEDICARE LIFETIME AUTHORIZATON

HIC#_____

Medicare Certification for Payment

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Request that this authorization also apply to all other insurance.

Signed: _____ Date_____

Printed Name: _____ Title or Relationship: _____

Witnessed by: _____ Address: _____

If signed by other than the beneficiary, state the reason the patient was unable to sign: _____

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