

SALEM NEUROLOGICAL CENTER, PA

DISCLOSURES & CONSENTS

Patient Name: _____ Date of Birth: _____
First Name M.I. Last

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Salem Neurological Center is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Salem Neurological Center.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I will receive a separate bill for lab, x-ray, CT, MRI, EEG, ultrasound, nerve conduction studies or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for services if they are not reimbursed by my insurance for whatever reason.

TELEPHONE CALLS:

You agree, independent of all other requirements, conditions or obligations, that you provide us with your prior express consent to receive telephone calls to your provided telephone number (cellular or otherwise) from us or our representatives by means of an automatic dialer and/or pre-recorded artificial voice messages.

CONSENT TO THE TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by Salem Neurological Center.

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE: _____
(If different from patient)

GUARANTOR NAME (Please Print): _____
First Name M.I. Last