Acknowledgment of Financial Policy

Patient Information

Last Name	*First Name*	*Middle Initial*	*Birth date*

I understand that I am ultimately financially responsible for all charges for services rendered by Evergreen Neurosurgery Center, PLLC. If my insurance coverage is under a plan in which Evergreen Neurosurgery Center does participate, including Medicare, I agree that I am responsible for all deductibles, copays, coinsurance payments and denied charges unless limited by insurance contracts or state or federal law.

I understand that payment not covered by my insurance carrier is due at the time services are rendered.

I understand that if I do not have insurance coverage, I will be responsible for payment of services at the time such services are rendered.

I understand that a $30.00 service charge will be applied for all returned checks.

I understand the office will copy my insurance card and driver's license.

I understand that it is my responsibility to notify the office in the event of a change in insurance.

I understand that I am responsible for paying my deductible and coinsurance before any surgical procedure. Failure to do so may result in my procedure being rescheduled.

I understand that Evergreen Neurosurgery Center, PLLC will comply with existing law regarding the use and release of my protected health information.

I authorize Evergreen Neurosurgery Center, PLLC to release, use and disclose my medical information in for my treatment, payment of services and healthcare operations.

Signature of Patient *Date*

X

Medicare Lifetime Signature

If I am a Medicare patient, I request that payment of authorized Medicare benefits be made on my behalf to Evergreen Neurosurgery Center, PLLC for any services furnished to me by Evergreen Neurosurgery Center, PLLC and its providers. I authorize the release of health information or other data necessary for processing Medicare claims.

Signature of Patient *Date*

X

Private Insurance Authorization for Assignment of Benefits and Information Release

I authorize the payment of medical benefits be made on my behalf directly to Evergreen Neurosurgery Center, PLLC for any services furnished to me by its providers. I understand that I am financially responsible for any amount not covered by my contract. I authorize the release to my insurance company health information and other data necessary for processing insurance claims.

Signature of Patient *Date*

X