



CREDIT POLICY

ASSIGNMENTS AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Neuro Institute, Inc. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the therapist to release all information necessary to secure the payment of benefits, provide treatment, or “healthcare operations” as determined by the therapist. I authorize the use of this signature on all my insurance submissions.

NOTE: ALL COPAYS WILL BE COLLECTED AT TIME OF SERVICE.

Signature

Date

FOR MEDICARE PATIENTS-MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf of Neuro Institute Inc. for any services furnished to be by the therapist. I authorize any holder of medical information about me to be released to the Healthcare Financing Administration and its agents for any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “any other health insurance” is indicated in item 9 of the HFCA 1500 form, or elsewhere on approval claim forms or on electronically submitted claims, my signature authorizes releasing of the information to the insurer or the agency shown. In Medicare assigned cases, the therapist or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination by the Medicare carrier.

Signature

Date