NEUROLOGICAL SURGERY, P.C.
100 Merrick Road, Suite 128W – Rockville Centre, NY 11570
Phone (516) 255-9031 Fax (516) 255-6010

ADMITTING CONSENT AND FINANCIAL RESPONSIBILITY FORM

Consent for Medical Treatment. I give consent to Neurological Surgery, P.C. (the "Practice"), its staff, physicians and other practitioners to provide and perform such health care, tests, procedures, and other services that are deemed necessary or beneficial by the Practice for my health and well being.

Payment of Insurance Benefits. I, and/or my dependents, hereby authorize payment to the Practice of all monies and/or benefits to which I and/or my dependents may be entitled from government agencies, insurance carriers or others who are financially liable for my, and/or my dependents', medical care and treatment to cover the costs of care and treatment. I also certify that I and/or my dependent(s) authorize the Practice to pursue any and all appeals or legal remedies necessary to recover payment for services rendered to me and/or my dependent(s), by the Practice, including, but not limited to, internal or external appeals of benefits denials, and litigation in any appropriate court.

ERISA Designation of Authorized Representative. I hereby designate, authorize, and convey to the Practice, to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my authorized representative, and I convey to the Practice: (1) the right and ability to act on my behalf in connection with any claim, fight, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA. as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from the Practice and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

Signature on File (For Medicare patients). I certify that the information given to me in applying for payment under Medicare is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or The Center for Medicare and Medicaid Services, or its intermediaries or carriers, any information needed for this or a related Medicare claim I request that the payment or authorized benefits be made to me or on my behalf to the Practice for services provided by the Practice.

Authorized for Release of Information. By signing below, I authorize the Practice to release my health information: (1) to any requesting health care provider for my further diagnosis, care of treatment or for that provider's payment or health care operation purposes; (2) to any person or entity that may be responsible for billing/collection of claims for medical services or products; (3) to any person or entity which is, or may be liable to the Practice or me for all or part of the Practice' charges, including but not limited to, insurers, MCOs or other benefit plans or third party payers; (4) to any government agency or other organization. responsible for oversight of the Practice; (5) for the Practice's health care operations. I authorize the Practice to allow the individuals listed above to access such information through any medium including over the Internet and through the Practice's electronic medical record system.

Acknowledgement of Notice of Privacy Notice. I have received a copy of the Practice' Notice of Privacy Practices, and have had the opportunity to receive assistance in the understanding and exercising these rights.

Signature. I have carefully read and fully understand this financial responsibility form and have had all my questions answered.

Signature of Patient	Print Name	Date

Signature of Patient/legal Representative	Relationship to Patient