CONSENT FOR TREATMENT

Authorization for treatment release of medical information, and assignment of insurance benefits,

AUTHORIZATION TO RELEASE: I hereby authorize The Neurological Care Center of Montgomery, P.C. of my attending physician, to release or disclose information from my medical record pertaining to my treatment to insurance companies and/or outpatient benefits programs as needed to process insurance claims. This includes labs and all other medical information pertaining to my care.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign payment directly to The Neurological Care Center of Montgomery, P.C. benefits wherein specified and otherwise payable to me but not to exceed The Neurological Care Center of Montgomery, P.C. regular charges for medical treatment. I understand I am financially responsible for charges not covered by this authorization.

STATEMENT TO PERMIT PAYMENT OF MEDICAL BENEFITS TO PROVIDER / PHYSICIAN: I certify that the information given by me applying for payment under XVII of the Social Security Administration or its intermediaries or carriers is the correct information needed for Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organizations furnished the services or authorize such physician or organization to submit claims to Medicare for payment to me.

MEDICAID PATIENTS CERTIFICATION: I certify that I am a recipient of the Medicaid Title XLX Program and request the payment of authorized benefits be made on my behalf. I authorize any holder of medical or other information about me to make available to the EDS any requested information concerning medical, insurance, and financial records relating to my outpatient visits or hospital treatment. I hereby certify all insurance shall be assigned to The Neurological Care Center of Montgomery, P.C. or to my attending physician for services rendered. This office does not accept Medicaid as a Secondary Insurance.

CONSENT FOR TREATMENT: The undersigned authorized the physician assigned to furnished medical and surgical treatment by those means she considers necessary and proper in the treatment of patient identified below while a patient of The Neurological Care Center of Montgomery, P.C. This treatment may require diagnostic procedures including but not limited to laboratory test, blood drawing for those tests.

FINANCIAL AGREEMENT: For services rendered to the patient named below, I, the undersigned, agree to pay all professional, outpatients and/or hospital visits charges not covered by insurance. I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment.

VALUABLES: The undersigned hereby releases The Neurological Care Center of Montgomery, P.C., and/or its staff or employees for any responsibility due to loss or damage of any valuables that the patient may keep in her or her possession or that may be brought to his or her by other person.

TERM: The term of this Consent for treatment shall be as long as the patient is a patient of The Neurological Care Center of Montgomery, P.C. unless otherwise revoked.

_____	_____	_____
Printed Patient Name	Signature Patient / Guardian	Date