Mischer Neuroscience Associates

Please list persons (including family, friends, and previous treating physicians) with who we may share information.

Name	Relationship

Financial Responsability

Mischer Neurosurgical Associates bill your insurance as a courtesy, even if he is held responsible for the entire account when providing the services. If your insurance does not send us the corresponding payment within 60 days, the applicable balance must be paid by you in full. Unless your insurer holds a contract with Mischer Neurosurgical Associates to pay based on a specific negotiated rate; you are responsible for any outstanding difference between the insurance payment and the total charges. Patients with plans to "managed care" must make their copays s corresponding day of his visit, as stipulated in the insurance contract.

Assignment of Benefits

I hereby assign all medical and surgical benefits, including major medical benefits to which I have right. I hereby authorize and direct my company health insurance, including Medicare, private insurance and any other insurance plan health / medical, issuing paychecks directly to MHS Physicians of Tx for medical services provided to me and / or my dependents regardless of my insurance benefits, should have them. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize my doctor Mischer Neurosurgical Associates (1) release any information necessary for health insurance companies regarding my illness and treatments; (2) processing insurance claims incurred in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of useful life. This order will remain in effect until revoked by me in writing.

I have requested medical services my doctor Mischer Neurosurgical Associates on behalf of myself and / or my dependents and I understand that by making this request, I become financially responsible for any and all charges incurred in the course of authorized treatment. .

I understand that the fees are due and payable on the date on which the services are provided and agree to pay all expenses incurred in full immediately after the submission of the declaration. A copy of this should be considered as valid as the original.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Print Patient's First & Last Name **Patient's Date of birth**

_____ _____

Patient/Guarantor Signature **Date**

_____ _____

Witness **Date**