NEW PATIENT AUTHORIZATION

AUTHORIZATION FOR TREATMENT:

I hereby authorize treatment of the person named below by Neuron Connect, I further agree to pay all fees and charges for such treatment promptly, upon presentation of a statement, unless prior arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. This office will provide a HCFA form for submission to my insurance company if I should request one. In the event legal action should become necessary to collect an unpaid balance, I agree to pay all reasonable attorney's fees or other cost of Court as are determined proper.

AUTHORIZATION TO SEND AND RECEIVE INFORMATION VIA EMAIL:

I hereby authorize Neuron Connect to contact me via email that has been provided.

ACKNOWLEDGMENT OF RECEIPT OF POLICIES:

I acknowledge that I have been shown a copy of the Notice of Patient's Rights. I further acknowledge that I either (1) was given a copy of said documents upon request or (2) do not need a copy of said document.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION:

I authorize all insurance benefits, unless previously paid by myself, to be paid to Neuron Connect and authorize the release of all information required in the processing of the insurance claim submitted on my behalf. I further authorize the release of all medical information deemed necessary for my health care to my referring physician, primary care physicians, spouse, children, parents, and any physician deemed necessary.

Patient Full Name: _____

Signature: _____ Date: _____