PRIVACY INFORMATION

This section must be completed to authorize Metrolina Neurological Associates, to release/discuss your health information with someone other than you (the patient). This release is good until you (the patient) make changes or cancels the authorization by informing us in writing.

LIST PEOPLE BELOW THAT WE MAY CONTACT OR SPEAK WITH ON YOUR BEHALF.

(Example: Family member(s) or anyone directly participating in ongoing medical care)

Name	Phone / Fax	Relationship

I, ____________________________________, have read and authorize Metrolina Neurological
(Patient Name and Date of Birth)
Associates to release my healthcare information to the above-listed people or organizations.

Signed: ____ Date: ____________________

ACKNOWLEDGEMENT AND AUTHORIZATION

I have read and understand the HIPAA/Privacy Policy for Metrolina Neurological Associates.

Signed ____ Date: ___________________

PATIENT FINANCIAL REPONSIBILITES:

- The patient is ultimately responsible for payment of treatment and care.
- If your insurance requires a referral to a specialist, it is **YOUR** responsibility to get the referral before your scheduled appointment or you will be responsible for the visit.
- We will bill your insurance for you; however, the patient is required to provide the correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, deductibles, and all other procedures or treatments not covered by your insurance plan.
- Co-pays are due at the time of service.
- Co-insurance, deductibles, and non-covered items are due 30 days from receipt of billing. If you are unable to pay within 30 days, we will be happy to set up a payment plan with you.

I have read and understood the Financial Policy for Metrolina Neurological Associates

Signed: ____ Date: ______________________