Patient Authorization

REGARDING BILLING: I authorize the NeuroMedical Center Clinic to accept assignment of insurance benefits and I understand that I am responsible for coinsurance, copayments, and/or deductibles at the time of service I understand that if my insurance is non-contracted (out-of-network), the clinic will complimentary file the claim for services rendered. In the event that I have no insurance, I understand that fees are due at time of service. A fee of $20 will be charged for all returned checks. I understand that previous balances owed will be requested at the time of registration. I understand that The NeuroMedical Center Clinic will refund to me any overpayment upon request, regardless of insurance.

In the event The NeuroMedical Center Clinic's charges for professional medical services are not paid timely, I understand that I will be legally responsible for all costs of collections, including 25% attorney's fees, court costs and legal interest.

I authorize The NeuroMedical Center Clinic's staff to release any medical information necessary to process my insurance forms. I further authorize The NeuroMedical Center Clinic's staff to disclose or release any medical information requested by attorneys, physicians, insurance companies, employers, health care providers, or any other entity which may be concerned with payment of the charges incurred at The NeuroMedical Center Clinic. I further authorize payment of medical benefits to The NeuroMedical Center Clinic.

REGARDING PRIVACY AND CONTACT: I have received a copy of the NeuroMedical Center Clinic's Notice of Privacy Practices if requested. I acknowledge and agree that The NeuroMedical Center Clinic or affiliates may contact me by phone or text message on any number I have provided.

REGARDING TREATMENT: I hereby authorize all providers at The NeuroMedical Center Clinic in charge of my care to administer any treatment, therapy or testing that may be deemed necessary or advisable in the diagnosis or treatment. I authorize The NeuroMedical Center Clinic’s staff to obtain my medication history for purpose of treatment.

REGARDING PHYSICIAN OWNERSHIP: During the course of treatment you may be referred to The Spine Hospital of Louisiana for an outpatient procedure, test, referral or surgery. The Spine Hospital of Louisiana is a physician owned hospital and we are pleased to inform you that your physician may be an owner in the hospital. You have the option to select another facility where your physician is on staff.

REGARDING NO SHOW FEES: If I fail to arrive or fail to cancel my appointment with at least 2 business days’ notice, a Fee will be charged: $65 per hour for Psychology Testing, $50 for all Neurology, Diagnostic and Psychology non testing appointments, $50 for MRI appointments, and $25 for all Physical and Occupational Therapy appointments.

REGARDING PRESCRIPTION REFILLS: Telephone prescription refills must be requested Monday-Thursday between the hours of 8:30am and 5:00pm. Telephone prescription refills may be delayed due to the physician's necessity to review your record determining the appropriate medicine to prescribe. Also, please note that it is our belief that narcotic pain relievers are, in general, for short- term use only. These policies are in your best interest and we thank you for understanding.

I am electronically signing this document.