Patient Financial Responsibility Form

Thank you for choosing South Florida Neurosurgery as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- • The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for her treatment and care.
- • We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
- • Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by
  their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.
- • Patients may incur, and are responsible for the payment of additional charges at the discretion of South Florida Neurosurgery. These charges may include (but are not limited to):
  Charge for returned checks, Charge for missed appointments without 24 hours advance notice, Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or
  prescriptions.,Charge for the copying and distribution of patient medical records, Charge for extensive forms completion, Any costs associated with collection of patient balances.

Patient Authorizations

- By my signature below, I hereby authorize South Florida Neurosurgery and the physicians, staff, and hospitals associated with South Florida Neurosurgery to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
- I understand that I must check one or more of the following types of health information in order to indicate that I authorize that information type to be released to the necessary insurance companies, third party payors, and/or other physicians and/or healthcare entities required to participate in my care. By checking one or more of the following boxes, the health information I authorize to be released may include any of the following:
  Diagnosis, evaluation, and/or treatment for alcohol and/or drug abuse.
  Records of HTLV-III or HIV testing (AIDS test) result, diagnosis, and/or treatment.
  Psychiatric and/or psychological records, or evaluation and/or treatment for mental, physical, and/or emotional illness, including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluations.
- By my signature below, I hereby authorize assignment of financial benefits directly to South Florida Neurosurgery and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize South Florida Neurosurgery personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

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Signature of Patient or Guardian Date

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

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Signature of Patient or Guardian Date