Mir Neurology
NeuroSpine Center

PATIENT AUTHORIZATION

I here certify that this visit is NOT due to any work-related injuries and/or illnesses _____ (initials)

I hereby certify that this visit is NOT due to any motor vehicle accident related injury _____ (initials)

FINANCIAL RESPONSIBILITY

I understand that I am required to pay my co-pay, co-insurance and any deductible that is required by my insurance company on the day of my scheduled appointment. Failure to do so may result in a service fee. I also understand that I may receive future statements once all payments from my insurance have been made in their entirety. Any outstanding balance, after insurance has paid, will be invoiced to me on a statement. Payment is due upon receipt of the statement. I understand nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

I agree to be financially responsible for any balance due. If my account becomes assigned to a collection agency, I agree to pay 35% of the collection agency fees, court costs and attorney fees. I understand that all accounts with a balance over 30 days may be assessed a 1.5% late charge per month (18% per annum) on the unpaid monthly balance. I also acknowledge that I may be discharged from the practice.

Mir Neurology has instituted service fees which may be applied to services in the following area:

1) Failure to cancel an appointment at least 24 hours in advance or a missed appointment may result in a missed appointment fee.
2) A returned check due to insufficient funds.
3) Medical record transfer may result in a preparation charge and per page charge as regulated by the State of Maryland.
4) Completion of FMLA, Disability, Letter of Medical Necessity and insurance authorizations for medication may result in a service fee.

I understand that my insurance company might now allow payment for all services. In addition, I understand that certain services and/or conditions may require pre authorization. Failure to have the pre authorization on file with my insurance will result in the balance being my full responsibility.

I agree to pay the laboratory for all services not covered by my insurance company. In addition, I understand that I am responsible for all co pays and deductibles per my insurance contract. If I am not insured at the time of service, I understand that I am fully responsible for all lab related charges. I agree to pay the lab for all lab services received.

Signature of Subscriber/Beneficiary: _____ (SEAL) Date: _____

Printed Name of Subscriber: _____ Date: _____