

NORTH JERSEY BRAIN AND SPINE CENTER

PATIENT'S NAME _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, deductible and co payments regardless of insurance coverage unless forbidden by prior insurance contracts. You are expected to pay for services at time they are rendered unless other arrangements have been made in advance.

I hereby authorize North Jersey Brain & Spine Center to furnish to insurance companies, their representatives or designated attorney and requesting physicians, any information concerning my (my dependents) illness and treatments. I hereby assign to North Jersey Brain & Spine Center all payments for medical services rendered to myself or my dependents. I agree that if my insurance company sends me a check for services rendered to me or my dependants by North Jersey Brain & Spine Center, I will endorse this check and forward it to North Jersey Brain & Spine Center within five days.

I understand that I am responsible for co payment, deductible or for any amount not covered by my insurance. If any collection proceedings are required to cover any outstanding balance, I understand I will be responsible for said costs including attorney fees of 33.33% of the unpaid balance. These costs are above and beyond any balance for services rendered.

Signature of patient _____ **Date** _____

Signature of insured _____ **Date** _____