FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

Patient Name: _____

To provide timely and accurate payment for any services furnished to the patient listed above
• I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.
• I assign my right to receive payment of authorized benefits to Optimum Neurology
• I request that payment of authorized benefits be made on my behalf to Optimum Neurology for any services furnished
• I authorize Optimum Neurology to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided.
• If my Health Insurance Plan will not direct payment to Optimum Neurology, I agree to forward to Optimum Neurology all health insurance payments which I receive for the services rendered by Optimum Neurology
• I authorize Optimum Neurology or any holder of medical information about me or the patient listed above to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.

I further acknowledge and agree:
• That I am responsible for all charges for services provided to the patient listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
• That I agree to pay all charges which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
• That this financial form with assignment of benefits applies and extends to subsequent visits and appointments at Optimum Neurology

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

_____	_____	_____
Patient/Person Legally Responsible	Relationship to Patient	Date