NEUROSURGICAL CONSULTANTS OF SOUTH FLORIDA
SPECIALIZING IN SURGERY OF THE BRAIN AND SPINE

David P. Sachs, M.D.F.A.C.S. Lloyd Zucker, M.D.
Evan Packer, M.D. Martin Greenberg, M.D.PhD

PATIENT FINANCIAL RESPONSIBILTY AGREEMENT

Financial Agreement

You agree to be responsible for and pay in full all charges by Neurosurgical Consultants of South Florida, L.L.C.'s ("NCSF") for treatment, services, and supplies provided to you. Payment is due upon receipt of our statement for services rendered. As a courtesy to you, NCSF will bill your insurance company, health maintenance organization or managed care company ("your health plan") for the medical services and supplies we provide to you. In billing your health plan, NCSF will rely upon the information you provide, including your current insurance identification card or other evidence of valid coverage. If your health plan changes in any way or your coverage terminates, please notify NCSF immediately so that we may update our records. It is particularly important to provide us with current and accurate billing information because the unpaid balance on your account will begin to incur an interest charge forty-five days after the date of the invoice. Interest will accrue at a rate of 1-1/2% per month.

If your health plan is a health maintenance organization, you are only responsible under Florida law for payment of deductibles, co-payments and charges for non-covered services as specified in your plan. As a patient enrolled in a health maintenance organization, you may be required to first contact your primary care physician before seeking any other medical care. Your health plan may require that your primary care physician or a contracted specialist physician refer you to us or obtain a prior authorization before you are referred to us for any medical services. If you do not comply with your health plan's policies and procedures, payment for the services we render could become your responsibility. If you are unsure of your obligations, please ask us. We will be pleased to help you clarify your obligations at any time. But, as the member of the health plan, it is your responsibility to ensure that you meet the obligations set forth in your plan documents.

NCSF's efforts to bill and collect on your behalf from your health plan and NCSF's acceptance of payment from your health plan will not relieve you of your obligation to make payment to NCSF in full. The amount your health plan pays NCSF may be less than the full charges or the amount you owe to NCSF. NCSF will credit all payments received from your health plan to your account and will bill you for the balance, unless otherwise provided under Florida law or if NCSF contracts with your health plan to accept the amount paid by them as payment in full.

All deductibles and co-payments required by your health plan are your responsibility. NCSF is prohibited by law from waiving deductibles and co-payments.

If payment is not made at any time and NCSF engages an attorney to assist in collection, you will be responsible for all fees and costs NCSF incurs in connection with its collection efforts. Your responsibility for the fees and costs NCSF incurs will be in addition to the charges and interest accrued on your account.

Advance Payment

You are required to make an advance payment of $_____.___ to NCSF prior to the provision of any further medical services. NCSF will apply this payment to your account and bill you for any balance due. If we bill a health plan on your behalf and receive payment, we will credit the payment to your account and send you a statement reflecting the balance due. If at the time of the conclusion of our services there is a credit balance on your account, we will refund the balance to you.

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Assignment of Insurance Benefits

You hereby authorize payment to be made directly to NCSF and assign to NCSF all Medicare and other insurance benefits that may be due and payable to you or on your behalf for any serviced and supplies rendered to you by NCSF. You hereby authorize NCSF and any other holder of medical or other information about you, including any Medigap insurer, to release to the Social Security Administration, the Centers for Medicare and Medicaid Services, and their agents, intermediaries and carriers, any information needed to determine the benefits or benefits payable to you for any claim with respect to NCSF's provision of health care services and supplies. Where Medicare and Medicaid benefits are applicable, you certify that the information given in applying for payment under Title XVIII or XIX of the Social Security Act is complete and correct. **You authorize NCSF to use this Agreement as evidence of your consent to bill and receive payment for health care services and supplies provided to you by NCSF. You further acknowledge that this assignment of benefits does not in any way relieve you of your liability to make payment to NCSF, and that you will remain financially responsible to NCSF until all charges for which you are legally responsible are paid in full. In the event the insurance carrier mistakenly sends payment for the claim directly to me, I agree that I will remit payment in its entirety to Neurosurgical Consultants of South Florida.**

Authorization for Appointment of Designated Appeal Representative of Designated Appeal Representative

I_____, authorize Neurosurgical Consultants of S. Fl, LLC to act as my representative in connection with the filing of an appeal on my behalf regarding a denial for the above referenced date(s) of service. I authorize (insurance carrier)_____to release any of my protected health information including benefits and policy information to Neurosurgical Consultants of S. Fl, LLC for the purpose of resolving this appeal. I understand that this information is privileged and confidential and will only be released as specified in this authorization or as required pr permitted by law.

I understand that I may revoke this authorization at any time by mailing a written notice to (insurance carrier)_____. I understand that revoking this authorization will not affect any action taken prior to my notice of revocation. My designated appeals representative also has the fight to rescind consent at any time.

I have read this consent or have had it read to me and it has been explained to my satisfaction. I understand that I am granting my consent for my representative to file an appeal on my behalf.

I have read and understand each of the above paragraphs and I acknowledge and accept these terms and conditions.

x_____ Date:_____
Signature of Patient or Guardian/Representative

_____ _____
Print Name Patient's Social Security Number

_____
Signature of Designated Representative of
Neurosurgical Consultants of S. FL, LLC

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Authorization to Release Medical Record Information

NCSF will use and disclose your health information only for purposes of treatment, payment, and health care operations, unless you authorize us to use or disclose your health information for other purposes.

*You hereby authorize your physicians, hospitals, and health care facilities to disclose all or any part of your medical record to NCSF in connection with treatment, payment and health care operations for treatment and services provided to you by NCSF.

*This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may affect or limit the insurance coverage for treatment, services, or supplies provided by NCSF.

***Please list the names of family members or care givers we may speak with regarding your health information. We will not give any information out to anyone not listed on this form. ***

1 _____ **2** _____

3 _____ **4** _____

5 _____ **6** _____

OR

Do not leave me a message or release information to anyone. Speak directly with me before releasing medical information

_____ Date_____
Signature of Patient or Guardian/Representative

_____
Print Name