METROPOLITAN
NEUROSURGERY

# CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby authorize Metropolitan Neurosurgery Associates, P.A. (also at times referred to as MNA) to use and/or disclose my health information which specifically identifies me or which can be reasonably be used to identify me to carry out my treatment, payment and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, MNA can refuse to treat me.

I have been informed that Metropolitan Neurosurgery Associates, P.A. has prepared a notice (HIPAA, Notice of Privacy Practices) which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care operations. I understand that I have the right to review such Notice which is displayed in the waiting area and copy can be provided to me at my request, prior to signing this consent.

I understand that I may revoke this consent at any time by notifying MNA in writing, but if I revoke my consent, such revocation will not affect any actions that MNA took before receiving my revocation.

I understand that MNA has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that MNA restricts how my individual identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that MNA does not have to agree to such restrictions, but that once such restrictions are agreed to, MNA must adhere to such restrictions.

**X**_____ _____

**Signature of patient or patient's representative** **Date**

(Form MUST be completed before signing)

_____ _____

**Printed name of patient or patient's representative** **Relationship to Patient**

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Our physicians are Medicare Participating Providers. We will bill Medicare directly and accept assignment. Medicare will pay 80% of the Medicare allowed charges and you, the patient, are responsible for 20%. You are also responsible for your annual deductible and any non-covered service.

We will submit all claims to the insurance carrier for you as long as you provide our office with your current/correct insurance information. We do not participate with any insurance plans aside from Medicare. You the insured are responsible for deductible and co-insurance portions not covered by your plan.

**LIFETIME INSURANCE SIGNATURE FORM:**

I request payment of insurance benefits, (i.e., Medicare, commercial, PIP, Worker's Compensation, or any type of policy I am covered under), be made directly to the provider of services. Metropolitan Neurosurgery Associates, P.A., and affiliated physicians on my behalf. I authorize release of any medical information necessary to process an insurance claim or determine benefits. Patients sent here for IME's are not responsible for payment.

I hereby authorize Metropolitan Neurosurgery Associates, P.A. to release any information acquired in the course of my treatment and examination. I hereby assign to Metropolitan Neurosurgery Associates, P.A. all money to which I am entitled, for medical or surgical expenses and services provided by any of their affiliated doctors (Dr. Steinberger, Dr. Moore, or Dr. Arginteanu). I agree to forward any payment made to me by insurance for services rendered by Metropolitan Neurosurgery Associates, P.A. directly to their office upon receipt of such payment with the EOB attached. I understand that any insurance money paid to me for services by Metropolitan Neurosurgery Associates, P.A. and not forwarded to same to satisfy payment for services rendered will be pursued according to law.

I understand that I am responsible to follow up with my insurance for payment for services provided to assure timely payment. Any charges over 90-days are subject to collections by an outside agency or attorney. I agree to pay all costs involved with collection procedures.

Further, I understand that I am entering into a contractual relationship with Metropolitan Neurosurgery Associates, P.A. for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Metropolitan Neurosurgery Associates, P.A. (Dr. Steinberger, Dr. Moore, or Dr. Arginteanu), I the undersigned patient and/or my representative agree not to advance, directly or indirectly, any false meritless, and/or frivolous claim(s) of medical malpractice against Metropolitan Neurosurgery Associates, P.A.

I certify that I have read this document, agree to its content, and that all information stated is true and correct to the best extent of my knowledge. This contract is effective from the date of first service.

**X**_____ _____

Signature of patient or authorized representative Date