



**AUTHORIZATION:**

I authorize Northern Indiana Neurological Institute, P.C. to release any information acquired in the course of my examination or treatment to other physicians, medical facilities, and/or insurance carriers. However, this office does not take responsibility for any further disclosures made by those parties. I authorize my insurance company to make payment to the provider. This authorization shall remain in effect until revoked in writing.

\_\_\_\_\_  
Signature of Patient/Legally Responsible Adult

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

**POLICY AND AGREEMENT:**

In consideration for medical services rendered by the Northern Indiana Neurological Institute's staff and physicians, I agree as follows:

That all fees and charges shall be paid promptly upon their presentment unless other arrangements have been made with the office manager in writing. While office visits are paid at the time of service, if I have insurance coverage for any other charges, it is my responsibility to provide forms and/or insurance numbers with the understanding that the processing of insurance forms by Northern Indiana Neurological Institute is done as a convenience to the patient, and the doctor is not responsible for assuring or waiting for payment by the insurance company. The responsible parties agree to be liable on all unpaid charges including any costs of collection, court costs, and attorney fees;

In the event that insurance benefits for services provided are paid directly to the patient or responsible party, it is agreed that such sums, up to the amount of any unpaid indebtedness, will immediately be paid to Northern Indiana Neurological Institute.

I will be responsible for work comp claims only if 1) the work comp carrier denies authorization for treatment; 2) after treatment, the work comp carrier deems my condition is not work related and denies payment; or 3) in the course of treatment the physician discovers another condition that is not work related and I accept treatment.

If your appointment is for an Independent Medical Examination that has been requested and paid for by a third party, you should be aware that your examination is for the purpose of medical opinion only and does not create a doctor/patient relationship. No treatment will be given. In addition, the doctor will not be liable for any alleged negligent performance of the IME.

This authorization shall remain in effect until revoked in writing.

**I HAVE READ AND ACCEPTED THE ABOVE POLICY AND AGREEMENT.**

\_\_\_\_\_  
Signature of Patient/Legally Responsible Adult

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date