Dear Patient:

It is the patient's responsibility to know his insurance plan. If this information cannot be provided correctly at the time of the visit, we cannot be responsible for any reimbursement for incorrect billing.

I hereby certify that I have been made aware of the above information and agree to abide by it.

_____ _____

Patient's Signature Date

My insurance plan is: _____

This is a _____ PPO

_____ HMO

_____ Group

_____ Medicare (If you are covered by Medcare,please read and sign the paragraphs below.)

MEDICARE PATIENTS

_____ Office Consultation

_____ Return Office Visit

	Yes	No
Have you seen a neurologist in the past two years?	_____	_____
Have you had 4 office visits this month?	_____	_____
Do you have a referring physician?	_____	_____

PHYSICIAN NOTE

*Medicare will only pay for services that it determines to be 'reasonable and necessary' under Section 1892 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is 'not reasonable and necessary' under Medicare program standards, Medicare is likely to deny payment for today's visit for the reasons:

"You have have already seen 4 physicians this month". or "You do not have a referring physician for this consultation." or "You have seen another neurologist in the past two years."

BENEFICIARY AGREEMENT

"I have been notified that, in my case, Medicare is likely to deny payment for the services identified above, for the reason stated. If Medicare denies payment, I agree to be personally and fully responsisble for payment."

_____

Patient's Signature

_____

Medicare #

_____

Date