

I hereby authorize my insurance benefits to be paid directly to Four Peaks Neurology. I am aware that I am financially responsible for non-covered services and any co-payments required by my insurance company. If a referral is required and you schedule an appointment without said referral, you will be responsible for the office visit fee. I also and responsible to provide all information that is required to secure payment for services rendered.

Patient Signature

Date

I hereby authorize Four Peaks Neurology to leave messages containing medical information (i.e. Lab results) on my voice mail/answering machine.

Agree Disagree

Patient Signature

Date