NEUROSURGERY ARKANSAS

9601 LILE DRIVE, SUITE 310
LITTLE ROCK, ARKANSAS 72205

PLEASE LIST ALL APPLICABLE INSURANCE COVERAGE. FAILURE TO PROVIDE ALL COVERAGE COULD RESULT IN REDUCTION OF BENEFITS.

COMMERCIAL INSURANCE

PATIENT'S NAME: _____

PRIMARY INS.:_____ GROUP NO.:_____ POLICY NO.: _____

ADDRESS: _____

SUBSCRIBER'S NAME AND SSN:_____ DATE OF BIRTH: _____

SUBSCRIBER'S EMPLOYER: _____

SECONDARY INS:_____ GROUP NO.:_____ POLICY NO.: _____

ADDRESS: _____

SUBSCRIBER'S NAME AND SSN:_____ DATE OF BIRTH: _____

SUBSCRIBER'S EMPLOYER: _____

I HEREBY REQUEST AND AUTHORIZE MY INSURANCE COMPANY AND/OR COMPANIES TO PAY DIRECTLY TO NEUROSURGERY ARKANSAS, 9601 LILE DRIVE, SUITE 310, LITTLE ROCK, ARKANSAS 72205, ANY PROCEEDS PAYABLE UNDER THE TERMS OF MY POLICY AND/OR POLICIES. I UNDERSTAND THAT ANY UNPAID BALANCE NOT COVERED BY MY POLICIES IS MY OBLIGATION AND WILL BE PAID BY ME. I HEREBY AUTHORIZE RELEASE OR INFORMATION TO MY INSURANCE COMPANY AS REQUIRED IN MY COURSE OF TREATMENT.

SIGNATURE:_____ DATE: _____

MEDICARE

_____	_____	_____
MEDICARE NUMBER	MEDIPAK NUMBER	MEDICAID NUMBER

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO NEUROSURGERY ARKANSAS FOR ANY SERVICES FURNISHED ME BY ANY PHYSICIAN OF THAT GROUP. I HEREBY AUTHORIZE AND HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNATURE:_____ DATE: _____

FINANCIAL AGREEMENT

I PROMISE TO PAY FOR SERVICES PROVIDED TO THE ABOVE MENTIONED NAMED PATIENT, I AGREE TO PAY SAID DOCTOR, ITS AGENTS AND ASSIGNS ALL MONIES WHICH SHALL BECOME DUE. THE DOCTOR WILL BILL ALL INSURANCE COMPANIES AT NO CHARGE PROVIDING WE HAVE AN INSURANCE ASSIGNMENT AND AUTHORIZATION WHEN REQUIRED.

SIGNATURE:_____ DATE: _____