

# NEUROSURGICAL SPECIALISTS, INC

## FINANCIAL RESPONSIBILITY STATEMENT AND INSURANCE ASSIGNMENT REQUIREMENT TO BE READ AND SIGNED

PATIENT: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

PATIENT'S AGENT/RESPONSIBLE PARTY: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

I REPRESENT TO NSI THAT MY MEDICAL INSURANCE CARRIER(S) IS (ARE) AS FOLLOWS:

PRIMARY: \_\_\_\_\_  
ID/CONTRACT NO.                      GROUP NO.                      NAME OF INS.CO.                      POLICY HOLDER

SECONDARY: \_\_\_\_\_  
ID/CONTRACT NO.                      GROUP NO.                      NAME OF INS.CO.                      POLICY HOLDER

OTHER: \_\_\_\_\_  
ID/CONTRACT NO.                      GROUP NO.                      NAME OF INS.CO.                      POLICY HOLDER

**FINANCIAL AGREEMENT:** I understand that this Agreement contains legally binding terms and provisions relating to payment for services and products provided and treatment rendered by Neurosurgical Specialists, Inc. ("NSI"). If I sign this Agreement as the Patient or the Responsible Party, I will be directly responsible for performing all obligations and paying liabilities arising under it. If I sign as the Patient's Agent, the Patient will be responsible for performing all such obligations and paying all such liabilities, unless I have misrepresented my authority to act on behalf of the Patient and bind the Patient to this Agreement. In that case I will be directly responsible for performing all obligations and paying all liabilities arising under this Agreement, just as if I had signed as the Responsible Party.

I authorize NSI to (1) file any medical insurance claims with my insurance carrier(s) listed above (2) release medical information to such carrier(s) and (3) receive direct payment of any amounts due on my claims with the carrier(s) listed above. I understand that NSI cannot accept the responsibility for collecting on an insurance claim or negotiating a settlement on a disputed claim. I agree that I am responsible for any co-settlements on a disputed claim. I agree that I am responsible for any co-payments, deductibles and fees for non-covered services. I understand and agree that if I am registered under litigation or workers' compensation, I will not delay payment for services rendered while awaiting any settlements, judgements or insurance carrier payments.

The undersigned understands that NSI is not in the business of extending credit or promises to pay NSI at the same time its bill is presented, unless other terms have been agreed to in writing by NSI. If prompt payment is not made, the undersigned understands that NSI may immediately take action to collect its charges. The undersigned agrees to pay all costs and expenses incurred by NSI in collecting its charges, including an attorney's fee of thirty percent (30%) of the unpaid bill.

Each person signing this Agreement certifies that he or she has read it, understands it, and has received a copy of it, and also that he or she is either (1) the Patient named at the beginning of this Agreement, (2) the Patient's Agent duly authorized to sign this Agreement for the Patient and to bind the Patient to its terms, or (3) the Responsible Party who, even though not the Patient, agrees to perform all obligations and pay for all liabilities arising under this Agreement.

PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT'S AGENT: \_\_\_\_\_ DATE: \_\_\_\_\_

RESPONSIBLE PARTY: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_