Neuro Medical Care
ASSOCIATES, PLLC
52 Harrison St 2nd Floor Johnson City, New York 13790

CONSENT FOR NEUROPHYSIOLOGIC SERVICES

By Appointment Only

Patient Name (Printed Name) _____ DOB _____

Consent to Diagnostic Testing: I authorize Neuro Medical Care Associates, PLLC and interpreting physician(s) to provide me with the necessary neurophysiologic testing as requested by my physicians(s). This consent and authorization includes intra-operative neurophysiologic testing, including but no limited to SSEP, MEP, EMG, and EEG. I further understand that any questions I might have as to testing can be addressed to my physician(s) or the technical personnel.

Authorize to release Information: I authorize New Medical Care Associates, PLLC and interpreting physician(s) to furnish requested information from the patient's medical and other records to (1) any insurance or third party payer for the purpose of obtaining payment on the account; (2) any other person(s) or entities financially responsible for the patient's care or treatment; and (3) representatives of local, state, or federal agencies in accordance with applicable law. I furthermore authorize the above-mentioned intraoperative monitoring company and interpreting physician(s) to release information from or copies of the patient's medical records to any referring physician(s) or to any health care facility to which the patient may be transferred.

Assignment of Benefits: In consideration of medical services provided to me, I hereby promise to pay for those services in accordance with the rates and terms now in effect and I authorize Neuro Medical Care Associates, PLLC and interpreting physician(s) to the extent that I am legally responsible for such payment. I hereby assign to and authorize the above-mentioned intraoperative monitoring company and interpreting physician(s) any and all benefits and all interest and rights (including causes of action and the right to enforce payment, and appeal insurance denials) for services rendered under any insurance policy.

Assignment of Rights: I, _____, hereby assign to and authorize Neuro Medical Care Associates, PLLC and interpreting physician(s) to the extent allowed by law, the right to collect the unpaid insurance benefits, penalties, attorney's fees, court cost, and all other recoverable damages of any nature from the medical insurance company that provided coverage on the date listed herein. The assignment of the right to sue the undersigned's medical insurance company in the undersigned's/insured's name and assert all claims that the undersigned/insured will have against the insurance company resulting from, or in way pertaining to, the medical coverage that the undersigned is alleged to have had with his/her insurance company in regard to medical procedures performed on this date signed below. Additionally the undersigned agrees to cooperate with and authorize Neuro Medical Care Associates, PLLC and interpreting physician(s) in providing documents and testimony concerning the rights assigned herein.

The undersigned certifies that he/she has read and understands the foregoing, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient Signature _____ Date _____

Interpreting Physician _____ Date _____

Phone 607-729-1521 Fax 607-729-7320 www.neuromedical.org
Taseer Minhas, M.D., Dharmesh Patel, M.D., Aamir Rasheed, M.D., Ahmad Alwan, D.O., Sherrie Adler, FNP-C, Doreen Yirenchi, FNP-C