BAY AREA NEUROLOGY, LLC

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Clinical Consultation
Electroencephalography
Electromyography, Nerve
Conduction Studies and
Infusion Therapy

DATE:______________________________

In the event that I do not have current insurance coverage and due to the lack of information at the time of my appointment, I AGREE TO BE RESPONSIBLE FOR ANY DEBT THAT I MAY INCUR as a self-pay patient should my insurance fail to cover this visit.

Insurance claims must be submitted within a month of the visit and should I fail to provide adequate information for billing said claim within that time frame, I again, agree to be responsible for any debt that I may incur from today's visit.

YOU MUST LIST PRIMARY INSURANCE: (1)__________________________AND SECONDARY INSURANCE:(2)_____________________________AND/OR ANY ADDITIONAL INSURANCE TO BE BILLED IN THE ORDER IN WHICH THEY SHOULD BE BILLED.

____
PRINT PATIENT'S NAME

____
PATIENT'S SIGNATURE

In association with the Maryland Neurological Institute

"Offering compassionate care in the diagnosis and treatment for diseases of the spine and central nervous system."