Privacy Policy and Medical Records Release

My signature below indicates that I have reviewed a copy of the "Notice of Privacy Practices" for Clinical Neurosurgical Associates of Dallas, and that if I have any questions regarding this notice, that I can discuss it with the designated
Privacy Officer: Karen Moore

Clinical Neurosurgical Associates of Dallas
221 W. Colorado Blvd
Pavilion 1, Suite 155
Dallas, TX 75208
214-941-7724 ext 10 Fax 214-948-8946

Below is my list of people with whom, I give permission to discuss my healthcare. This does not include doctors and Worker's Compensation. Records are routinely released to referring physicians and adjusters with Worker's Compensation.

1. ____
2. ____
3. ____
4. ____
5. ____

Patient Signature_________________________ Date_________________

I agree to the assignments and financial responsibilities shown below on this form.
Patient Signature _________________________ Date______________

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and other pay a percentage of the charge. It is the responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT. If this account is assigned to an attorney for collection and/ or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection. I authorize the release of any information necessary to determine liability of payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on this form. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for all charges whether or not paid by said insurance.

Name _________________________ DOB___________ ID___________