NEUROSCIENCE CONSULTANTS

DIPLOMATES, AMERICAN BOARD OF NEUROLOGY

ALLAN HERSKOWITZ, M.D., F.A.C.P.
BRAD HERSKOWITZ, M.D.
PAUL DAMSKI, M.D.
BERNARD GRAN, M.D.
GUILLERMO A. MARTINEZ, M.D.
MARK BRYER, M.D.

Financial Agreement:

The undersigned agrees to pay the Neuroscience Consultants LLC for services rendered. I further agree that payment is due upon receipt of the statement. I understand that unpaid patient balances will be considered in default after a (60) day period. If this were to occur then legal action will be necessary to enforce payment on the account. I agree to pay the attorney's fee and any legal fees as may be deemed reasonable. The patient/guardian waives venue jurisdiction and submits to the jurisdiction and venue of the state courts of Miami-Dade County, Fl.

Patient/Guardian:____________________________Date:_______________

Assignment of Benefits:

I hereby authorize payment to be made directly to Neuroscience Consultants LLC of benefits due to me from my insurance company. I understand that I am financially responsible for charges not covered by the insurance company. In this case I will then immediately pay Neuroscience Consultants LLC for the services rendered. I authorize the release of any medical or other information necessary to process this claim.

Patient/Guardian:_______________________________Date:____________

HMO and Workman compensation patient notice:

You are responsible for obtaining a referral /authorization for your visits and or testing in our offices from your primary care physician or claims adjuster.

Patient/Guardian:____________________________Date:_______________