NASA
NEUROSCIENCE
AND SPINE ASSOCIATES, P.L.

Assignment of Benefits
Authorization to Release Information / Financial Responsibility

I hereby assign, transfer and convey all medical/surgical benefits, including but not limited to Major Medical, Medicare, private insurance, PIP, and any other health plan benefits to which I am entitled, as well as any cause of action arising from the nonpayment of such benefits to Neuroscience and Spine Associates, P.L.

This order will remain in effect until revoked by both parties in writing. A photocopy of this assignment is to be considered as valid as the original. In exchange for this assignment of benefits, Neuroscience and Spine Associates, P.L. will bill my insurance carrier directly. I understand that I am financially responsible for all charges, whether or not paid by said insurance company or carrier. I am aware that finance charges of 1.5% will begin accruing monthly when my bill is 30 days past due. I hereby authorize Neuroscience and Spine Associates, P.L. to release all information necessary to secure payment, including HIV information, to other lawyers, doctors and/or healthcare providers involved in my care.

I give permission to Neuroscience and Spine Associates, P.L. to take my picture for the sole purpose of identification by the Doctor and his staff.

_____ **Date:** _____
Patient / Responsible Party Signature

_____ **DOB:**_____
Patient's Name (Printed)