Texas Neurology Consultants, LLP
Daniel J. Hopson, M.D., P.A. Paul W. Hurd, M.D., P.A. Shari Rosen-Schmidt, M.D., P.A.
2800 North Dallas Parkway, Suite 210
Plano, TX 75093

Patient Name: _____Date of Birth:_____

Consent to Treatment: I hereby give my consent for medical treatment by the physicians or under the direction of the physicians of Texas Neurology Consultants, LLP

Patient or Guardian Signature _____ Date

Payment Policy: I understand that I am responsible for payment of professional services at the time they are rendered. I understand that I am responsible for any amount not covered by insurance including, without limitation, deductible, co-payment, co-insurance, or other amounts unpaid by my insurance, if benefits assigned. Texas Neurology Consultants, LLP files claims for Medicare assignment and only the managed care plans, which we are contracted. Claims will not be filed with other insurance carriers. If you plan to pay by check and it is dishonored a processing fee of $35 will be assessed.

Patient or Guardian Signature _____ Date

Assignment of Benefits: I assign to the treating physician of Texas Neurology Consultants, LLP all payments for medical services rendered to my dependents or myself for services filed to insurance on my behalf.

Patient or Guardian Signature _____ Date

Authorization for Release of Medical Information: I hereby authorize Texas Neurology Consultants, LLP to release any medical or incidental information that may be necessary for medical care or to process medical insurance claims.

Patient or Guardian Signature _____ Date

I authorize that messages may be left for the patient about appointment reminders and/or medical information regarding patient care:

At work _____ Initial On home answering machine _____ Initial With spouse or other family member _____ Initial

Name of spouse_____ Name of family member(s) _____

On a cell phone_____ Initial Number of cell phone_____

I may revoke consent for any or all of the above initialed items at any time in writing. I certify that all information provided to Texas Neurology Consultants, LLP is correct.

Patient or Guardian Signature _____ Date

MEDICARE PATIENT ONLY

I authorize the treating physician of Texas Neurology Consultants to release medical information about me to the Social Security Administration and the Health Care Financing Administration (HCFA) or its intermediaries, or carriers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Texas Neurology Consultants,LLP. Regulations pertaining to Medicare assignment of benefits apply.

Patient or Guardian Signature _____ Date

I also authorize the same release of information to any Medicare supplemental insurance entities (i.e. Medigap) and further request payment of medical insurance benefits to the party who accepts assignment.

Patient or Guardian Signature _____ Date