APNNA
Arizona Pediatric Neurology & Neurogenetics Associates, PLLC

3330 North 2nd Street, Suite 402
Phoenix, AZ 85012
Tel: 602-687-8555
Fax: 602-406-4067

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, AND FINANCIAL RESPONSIBILITY

PATIENT'S NAME: ____

INSURED'S NAME: ____

PHYSICIAN'S NAME: Dr. Vinodh Narayanan, MD

RESLEASE OF INFORMATION: I authorize the release of medical and financial information for the purpose of collection of my account. I also authorize the insurance benefits to be paid directly to my doctor and acknowledge that I am financially responsible for any unpaid balance. I agree to pay this balance in full, and if unable to pay in full, will make other arrangements with the billing department.

INSURED AGREEMENT: I am aware that my insurance carrier may require me to use participating providers and to follow plan requirements, including primary-care referral and pre-certification, and that failure to comply could result in my sole responsibility to pay any charges for services rendered.

I am aware that if APNNA is not a participating provider with my insurance plan, then I will be responsible for payment of all charges for services rendered. If any services provided or diagnoses made are considered by my insurance plan as being non-allowable, then I agree that I will be responsible for those charges.

SELF-PAY AGREEMENT: If I do not have insurance coverage, or if my insurance carrier does not cover this service, I agree to be responsible for the full balance. If I am unable to pay the balance in full, I agree to make other arrangements with the billing department.

Signature of Responsible Party: ____

Printed Name: ________________________________ Date: ______________________

APNNA Representative Signature: ____

Printed Name: ________________________________ Date: ______________________