

Dr. Miric Neurology Center

Authorization And Agreement For Payment

I understand that I am fully responsible for all fees payable to Dr. Miric Neurology Center for medical treatment rendered to me or a member of my family.

I authorize payment to all medical benefits for services rendered by Dr. Miric Neurology Center. In the event that I am denied insurance coverage, I will make arrangements to pay bills within thirty (30) days.

In the event that I am not successful in litigating any claim, I nevertheless understand that I must make payment for all my bills within a reasonable period of time, but not later than three (3) months.

By my signature below, I certify that I have read and understand the above or that all the above provisions have been fully explained to me.

(Patient Signature)

(Date)

(Patient Signature)

(Date)

Authorization To Release Information

This is to authorize Dr. Miric Neurology to furnish my attorney, insurance company, and/or treating physician any information and/or opinions, which they request, or to photostat the same.

(Patient Signature)

(Date)

(Patient Signature)

(Date)

Attention Medicare Patients

Patients who have the following secondary insurance companies please sign below:

Blue Cross & Blue Shield of National Capital Area	Torchmark Companies
Blue Cross & Blue Shield of Delaware	Inter-County Hospitalization Plan
Blue Cross & Blue Shield of New Jersey	Equicor
Pennsylvania Blue Shield 65 Special	Connecticut General
District of Columbia, Maryland, NJ and VA Medicaid	

I request that payment of authorized Medigap benefits be made either to me on my behalf or to Dr. Miric Neurology Center/Slobodan Miric, MD for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to Name of Medigap Insurer any information needed to determine these benefits payable for related services.

(Patient Signature)

(Date)