WELCOME TO THE PALM BEACH NEUROLOGICAL CENTER

MICHAEL M. TUCHMAN, M.D., FAAN
RHONDA SKILES, ARNP, NP-C
3355 BURNS ROAD, SUITE 201
PALM BEACH GARDENS, FL. 33410

AUTHORIZATION FOR TREATMENT/FINANCIAL AGREEMENT

I, hereby authorize **Palm Beach Neurological Center** to furnish Medicare, my/the patient's insurance company, attorney or any representative thereof, with any and all information requested regarding my/the patient's past and present physical condition and treatment.

I authorize the provider in charge of my/the patient's care to administer such medical care deemed advisable in my/the patient's diagnosis and treatment.

I authorize my/the patient's insurance company, attorney or Medicare to pay directly to the Palm Beach Neurological Center any medical and/or surgical expenses payable under the terms of my/the patient's contract. I also agree that any balance not covered will be paid by me/the patient and photocopies of this form will be valid. I agree that should this account be referred to an agency or attorney for collection, I/the patient will be responsible for all collection costs, attorney's fees and court costs.

MISSED APPOINTMENTS ARE SUBJECT TO A $100.00 FEE. TWO (2) BUSINESS DAYS' NOTICE IS REQUIRED FOR CANCELLATIONS. THIS FEE IS NOT COVERED BY INSURANCE. _____Initial

I UNDERSTAND AND ACCEPT THAT DR. TUCHMAN AND RHONDA SKILES, ARNP PROVIDE CLINICAL CARE IN THEIR OFFICE DURING REGULAR OFFICE HOURS, BUT DO NOT PROVIDE HOSPITAL CARE AND ARE NOT AVAILABLE FOR EMERGENCIES ON NIGHTS, WEEKENDS OR HOLIDAYS. _____Initial

I ALSO UNDERSTAND AND ACCEPT THAT IN THE EVENT OF AN EMERGENCY OUTSIDE OF OFFICE HOURS, I AM TO CONTACT MY PRIMARY CARE PHYSICIAN OR CALL 911 FOR ASSISTANCE.

I AGREE TO THE POLICIES OF THE PALM BEACH NEUROLOGICAL CENTER AND WISH TO BE SEEN.

_____

SIGNATURE OF PATIENT DATE

_____

POWER OF ATTORNEY/PLEASE SIGN AND PRINT NAME DATE

_____

WITNESS DATE

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. THANK YOU