2121 E. Harmony Road, Suite 180
Fort Collins, CO 80528
Phone: (970) 226-6111
Fax: (970) 226-6707

1551 Professional Lane, Suite 125
Longmont, CO 80501
Phone: (970) 805-0950
Fax: (970) 805-0955

Assignment of Benefits: If I am entitled to benefits of any type whatsoever arising out of any insurance policy or public entitlement insuring me or any other party liable to me, such benefits are hereby assigned to Advanced Neurology of Colorado for application to my bill.

I understand that billing of insurance or other benefits is a service only and is not a guarantee of payment. If the Payor does not pay within sixty (60) days of billing, I shall be financially responsible for the full amount of the bill. I will also promptly furnish, complete and sign any forms that may be necessary to obtain reimbursement from a Payor to Advanced Neurology of Colorado for services rendered.

Notice of Privacy Practices & Patient Rights: By signing below, I acknowledge that I have read a copy of the Notice of Privacy Practices. I give my consent to Advanced Neurology of Colorado to use and disclose my Protected Health Information ("PHI") as described in the Notice and as allowed by law.

Managed Care Statement: I recognize that Advanced Neurology of Colorado may not be considered a preferred provider by my managed care health insurance plan. I accept full financial responsibility for any charges not covered by my insurance as a result of my seeking services from a provider outside of my plan.

Financial Agreement: I agree to pay to Advanced Neurology of Colorado all co-payments at the time that the service is rendered. If I am unable to pay my co-pay at time of service, I understand there will be a $10.00 billing fee. I understand that if I have no insurance coverage, payment is due at the time of service unless prior arrangements have been made. Advanced Neurology of Colorado accepts cash, check, Visa, MasterCard and Discover. I understand that unpaid balances will be considered delinquent after sixty (60) days. All returned checks will be assessed a $20.00 returned fee for processing There is a $25.00 cancellation/no show fee on all appointments cancelled without a 24 hour notice.

I certify that I have read this Agreement that the information given by me in regards to my treatment is correct and I have access to a copy of it. I understand that no agent or employee of Advanced Neurology of Colorado is authorized to change or eliminate any provision of this Agreement. No alterations, additions or deletions shall change the obligations to which I have agreed.

_______________________________________ _____________________

Patient or Legal Guardian **Date**

_______________________________________ _____________________

Witness **Date**

Mutual Respect Policy

Our staff makes a sincere effort to treat every patient in our clinic with respect and professionalism. Please treat all members of our staff with the same courtesy you would expect from them.

Patient Identification:
Name: ___________________________
DOB: ____________________________
Gender: __________________________