Stoll
NEURODIAGNOSTICS

Release of Information

I authorize Stoll Neurodiagnostics, PA to release any information acquired in the course of my examination or treatment. Information may be released to physicians, insurance companies, employers, attorneys, health care providers or other entities which may be concerned with my health care services and/or the payment of charges incurred from services provided by Stoll Neurodiagnostics, PA. I authorize payment directly to Stoll Neurodiagnostics, PA for services rendered

_____ _____
Signature of patient Date

_____ _____
Patient name (Please print) Signature of parent if minor

Financial Policy

Thank you for choosing Stoll Neurodiagnostics, PA to provide you with EMG/NCS services. Please be aware that some or all services provided may not be covered by your particular insurance plan. Should your plan not cover all services, you will be billed for the services not covered. Payment plans are available. We accept cash, VISA, MasterCard, American Express, Discover cards and Care Credit.

If your insurance plan requires a co-pay or percentage of services payment, this amount is due at the time of your visit.

I have read and agree to the above policy. I understand that regardless of my insurance, I am responsible for payment of services rendered by Stoll Neurodiagnostics, PA. I authorize release of information to my insurance company for payment of claims for services rendered.

_____ _____
Signature of Patient Date

_____ _____
Patient Name (Please Print) Signature of Parent if minor