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ASSIGNMENT OF
BENEFITS/AUTHORIZATION FOR
TREATMENT:

I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf. I understand that I am financially responsible for all charges not covered by my insurance and it is likely there is a balance due. I understand that the copayment is expected at time when services are rendered. I understand that payment will be due when services are rendered without valid referral.

Patient or Authorized Representative

Date

The Neuroscience Center **does not participate** with the following insurance plans:

Healthnet
Oxford Liberty
Oxford Liberty HMO
United Healthcare
Qualcare HMO of St. Barnabas
Basic and Essential BC (see front desk)

GHI of NY
Medicare Advantage Plans
NJ Family Care
Americhoice