NEUROLOGY
SPECIALISTS

Patient Insurance Authorization

By signing this agreement, I am giving *Neurology Specialists, PA* permission to ask my insurance or insurances for payments for my medical care.

I understand that my insurances need information about me and my medical condition to make a decision about these payments. I give permission to *Neurology Specialists, PA* to give that information to my insurances and the companies that handle the payment requests.

I request that payment of authorized insurance benefits be made to *Neurology Specialists, PA* on my behalf for any services furnished to me by the physicians and staff of *Neurology Specialists, PA*. I authorize *Neurology Specialists, PA* to release to my insurances and their agents any information about me that is needed to determine my benefits for the services.

Patient Signature	By – If other than patient
	Reason – If patient unable to sign