3 Washington Circle NW
Suite 207/208
Washington, DC 20037

Main: (202) 955-6001
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Authorization for Nerve Bone & Joint Institute, PLLC

THE UNDERSIGNED PATIENT, OR AUTHORIZED INDIVIDUAL ACTING ON BEHALF OF THE PATIENT, UNDERSTANDS AND AGREES:

1. The physicians may administer medical care as necessary in the diagnosis and treatment of the patient.

2. The physicians are granted permission to release to the insurance company, employer or referring physician complete information regarding diagnosis and treatment.

3. To authorize payment of medical benefits directly to Nerve Bone & Joint Institute.

4. To pay all amounts as are or may become due for services rendered and in the event full payment is not made on my behalf from any third party, this obligation shall be my responsibility.

5. To be personally responsible for any appearance at deposition or court by the physician.

6. That should my bill for any services rendered be referred to an attorney and/or collection agency for collection, I am responsible for all court costs, service of process and fee of up to twenty five percent (25%) of the outstanding balance at the time of referral, which percentage and the amount resulting are considered reasonable by the undersigned. I also provide express consent to receive telephone calls on my home and cell-phone numbers by NBJI staff or collection agency for collection.

7. That my appointment time is reserved specifically for me and if I cannot make my appointment, NBJI asks for at least 24 hours notice of cancellation. If the appointment is not kept and at least 24 hours notice prior notice is not given, I will be charged $100 on my account.

8. That a 10% annual interest will be applied to any invoice balance that is outstanding for more than 30 days.

9. That when allowed under state and federal law, NBJI reserves the right to request and I agree to pay for any remaining or unpaid balance of my medical invoices.

10. That NBJI reserves the right to charge a $30 fee for preparing and/or completing all outside forms.

________________________________ ________________________________
Patient, Parent/Guardian (please print) Signature

Date ____________________________