NEUROSURGICAL SPINE SPECIALISTS™

R. Blaine Rawson, M.D.

www.NSSmichigan.com

Financial Responsibility

I understand that I am financially responsible to pay deductibles, co-insurance or any other balance not paid by my insurance; and that I am responsible to understand my insurance coverage.

*Signature: _____ Date: _____

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MEDICARE PATIENTS:

ASSIGNMENT OF BENEFITS:

I request that payment of authorized Medicare and Medigap benefits be made on my behalf to this provider for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Medicare ID#: _____

*Signature: _____ Date: _____