HAYNES NEUROSURGICAL GROUP, P.A.
801 Princeton Ave. SW, POB 1 STE 310
Birmingham, AL 35211
Dr. R Cem Cezayirli Dr. Robert J. Johnson, Jr.

Statement of Patient Financial Responsibility

PATIENT NAME: _____DOB:_____
(Printed)

Haynes Neurosurgical Group appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payments/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

In the event that your balance is not paid in full within the allotted time, you understand that collection procedures will begin. Collection procedures include, but are not limited to, a series of collection letters, being turned to a collection agency, 2.5% monthly interest dated back to the date of services performed, and having your account turned over to a lawyer. You waive all claims of exemption under the State of Alabama and agree to pay if necessary, all cost of collection, including attorney fees.

I have read the above policy regarding my financial responsibility to Haynes Neurosurgical Group, P.A., for providing medical/rehabilitative services to me or to the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Haynes Neurosurgical Group, P.A, the full and entire amount of the bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier is my responsibility.

PATIENT SIGNATURE: _____DATE: _____

GUARANTOR SIGNATURE: _____DATE: _____
(If guarantor is not the patient)