PEDIATRIC NEUROLOGY OF DALLAS
Mahshid Moein, M.D.
7777 Forest LN, Suite A-317 Dallas, TX 75230
972/566-5656 Fax 972/566-5627

Disclosure Agreement

Patient's Name: _____

Reason for Office Visit:

☐ New Patient Neurological Exam
☐ Follow-up Neurological Exam

FOR **NON-INSURED PATIENTS:**

I/my child does not have any form of medical/healthcare insurance including Medicare or any form of Medicaid (initials)_____

IF WE ARE CONTRACTED WITH YOUR INSURANCE AND WE ARE FILING WITH YOUR INSURANCE FOR YOUR OFFICE VISITS:

Check appropriate box(es)

☐ My insurance plan covers New Patient Neurological Exams.
☐ My insurance does not cover New Patient Neurological Exams.
☐ I do not know if my insurance plan covers New Patient Neurological Exams.
☐ My insurance plan covers Follow-up Neurological Exams.
☐ My insurance does not cover Follow-up Neurological Exams.
☐ I do not know if my insurance plan covers Follow-up Neurological Exams.

I recognize that I am responsible for providing my insurance information to Pediatric Neurology of Dallas at the time of service. If I do not have this information, I must pay for the visit and will be provided a statement to file with my insurance carrier myself. (initials)_____

I agree to pay for any and all medical services I receive from the physicians of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim on my behalf. However, if my insurance company denies payment for any reason (i.e. non-covered services, terminated coverage, my failure to secure a referral from my primary care physician), I will pay for service upon written/verbal notice of their refusal. Failure by your insurance company to pay for a "clean claim" within 45 days of filing is, for the purpose of this agreement, a refusal to pay. (initials)_____

_____ _____
Signature of Patient or Responsible Party Date

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DISCLOSURE OF MEDICAL/FINANCIAL INFORMATION TO FAMILY MEMBERS/FRIENDS

Patient Name_____ Date of Birth_____

In our effort to adhere to HIPAA guidelines, Pediatric Neurology of Dallas (PND) needs your authorization to release medical/financial information connected to your child's/your care. **Please complete the information below so that we may release any necessary information to your family member(s) or friends. If you are over the age of 18, you must give authorization for our physicians/staff to speak to your parents!**

Please check the appropriate box if you do **NOT** wish this information to be released.

☐ Please DO NOT release this information.

I, the undersigned, hereby authorize PND to disclose information from my child/my medical or financial record to the following family member(s) or friends:

Name:_____ Relationship:_____

Contact information:_____

Type of information that PND can provide to them: ☐Medical ☐Financial ☐Both

Name:_____ Relationship:_____

Contact information:_____

Type of information that PND can provide to them: ☐Medical ☐Financial ☐Both

_____

Signature of Parent/Patient (if over 18) Date