THE METROPOLITAN NEUROSURGERY GROUP, LLC

8401 Connecticut Avenue, NW Suite 220, Chevy Chase, MD 20815 | 301-654-9390 | 1-301-302-0911 F
Professional Staff Offices, DCH, 8116 Good Luck Rd, Suite 205, Lanham, MD 20706 | 1-301-302-0911 F

ACKNOWLEDGEMENT OF BILLING POLICY

Dr. Henderson does not participate in any HMOs, PPOs or commercial insurance plans, though we do participate in Medicare. Benefit information, referrals, and pre-authorizations as stated in the patient's insurance policy are the responsibility of the patient, though we will file with insurance companies for patients. For auto accidents or claims involving litigation, payment in full is required at the time of each visit.

Please be aware that payment is due in full at the time of service, as you're being treated by an "out-of-network" provider. The patient is responsible for all deductibles, coinsurance, and non-covered services. As your surgeon is not a part of your health insurer's network, you may pay more for the services provided, such as:

1. The charges may be higher than the amount your health insurer will pay and, if so, you must pay the difference;
2. Your coinsurance, deductible and out-of-packet maximum may be higher because your surgeon is not in your health insurer's network.

We will provide you an estimate of the cost of surgical services and the amount of the deposit necessary to schedule your procedure. We will do our best to provide you with caring and comprehensive treatment at a reasonable cost.

I have read the above and understand my financial obligation.

Patient/Guarantor Signature: ___________________________________ Date: ___________________

ASSIGNMENT OF INSURANCE

I hereby authorize payment directly to Metropolitan Neurosurgery Group, LLC (MNG) of the health insurance benefits otherwise payable to me during this or any future visit to MNG. I acknowledge that I can reverse this authorization at any time. Within 24 hours, a claim will be filed with my health insurance carrier. I will be notified when final action (payment, denial, etc.) has been received.

I have read and understand the terms of the above statement.

Patient/Subscriber Signature: ___________________________________ Date: ___________________

Witness: ____ Date: ___________________________