Center For Neurological Disorders, P.A.
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NEUROSURGERY
DIPLOMATES OF THE AMERICAN BOARD OF NEUROLOGICAL SURGEONS
GEORGE F. CRAVENS, M.D., F.A.A.N.S., F.A.C.S.
OLIVER KESTERSON,M.D. F.A.A.N.S.

PAIN MANAGEMENT
GERARD POCHE, M.D.

ASSIGNMENT OF BENEFITS

I hereby authorize assignment and payment directly to Center for Neurological Disorders, PA major medical benefits due me. Whereby no precluded by contractual agreement, I hereby agree to pay any and all charges that exceed or that are not covered by my insurance.

PRINTED NAME _____

PATIENT/SURROGATE SIGNATURE_____DATE_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Center for Neurological Disorders , PA to release information requested by my insurance company or Worker's Compensation carrier. I also authorize release of information to any hospital or physician to whom I may be referred by this office. In addition, I authorize the Center for Neurological Disorders to discuss my medical care with individuals listed below.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship_____

Name_____Relationship _____

PRINTED NAME _____

PATIENT/SURROGATE SIGNATURE_____DATE_____