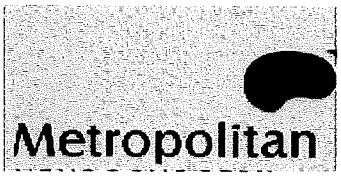

AUTHORIZATION AND CONSENT FORM

General Release of Information & Assignment of Benefits:
I authorize METROPOLITAN NEUROSURGERY, P.A., on behalf of myself and/or my dependents, to furnish medical records, including films and other information related to health care services provided by METROPOLITAN NEUROSURGERY, P.A., to Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, in which my providers participate, and the contractors and third party administrators of any of these parties as may be necessary for the payment of a bill, determination of benefits, utilization and quality review purposes, or health care operations. I hereby assign all authorized medical and surgical benefits to which I am entitled and I request payment of all such authorized benefits be made on my behalf to METROPOLITAN NEUROSURGERY, P.A. for any services furnished by METROPOLITAN NEUROSURGERY, P.A.

Release of Information by Payers and Networks:
I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, and their contractors and third party administrators to share my health records and information obtained from METROPOLITAN NEUROSURGERY, P.A. or any other provider, with METROPOLITAN NEUROSURGERY, P.A., other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which my provider participates, and the contractors and third party administrators of these parties as needed for payment and health care operations.

Payment Agreement:
I understand that I am financially responsible and agree to pay for any charges for the care and treatment rendered to me not covered by my insurance plan or if I do not have active insurance coverage. If circumstances require the use of a third-party collection agency, I understand that I will be responsible for payment of collections costs and/or attorney fees, if necessary.

Release/Retrieval of Information to/from Health Care Facilities, Pharmacy Benefit Payers and Providers:
I authorize the release or retrieval of my medical treatment information, including films, prescription medication history and other information related to such services for health care operations to or from third party pharmacy benefit payers, other health care facilities, and other providers who may be involved in my medical treatment.

Messages:
I authorize METROPOLITAN NEUROSURGERY, P.A. to use and disclose medical information to contact me in regard to an appointment, possible treatment options, or other benefits or services that may be of interest to me. METROPOLITAN NEUROSURGERY, P.A. may call me and, if necessary, may leave messages on my answering machine.

Patient Information:
I acknowledge that I have received the Notice of Privacy Practices from METROPOLITAN NEUROSURGERY, P.A.

I understand all of the above and I have had the chance to ask questions and all of my questions have been answered to my satisfaction. This consent does not expire until I revoke it and I understand that I must do so in writing. I understand that I have the right to revoke my consent at anytime and that my revocation shall have no effect on any actions taken prior to my revocation.

_____ _____
Patient's Name Date

_____
Signature of Patient or Personal Representative

_____
Relationship to Patient (if patient unable to sign)