

INSTRUCTIONS:

1. Complete the patient information, Today's Fee, Previous Balance, Today's Payment and the resulting IOU
2. Obtain patient's signature and provide the patient with a copy of form, while retaining the original for your office.
3. Ask patient to detach and return the bottom portion with payment.
4. Include the signed copy of the IOU in today's scanning.



NEUROCARE CENTER, LLC

8815 CENTRE PARK DR. SUITE 220
COLUMBIA MD 21045
Ph# (410) 730-6911

IOU-INVOICE

Pat. Acct #: _____

Date: ____/____/____

PATIENT'S NAME: _____ / _____ / _____
LAST FIRST MI

STREET ADDRESS _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

SEX: M F DOB: ____/____/____

Today's Fee	+	
Previous Balance (if any)	+	
Today's Payment*	-	
IOU	=	

*Today's payment made by:
 Cash Credit Check #

NOTE:

PATIENT AGREES TO PAY THE AMOUNT DETAILED ABOVE WITHIN FIVE (5) DAYS. ALTHOUGH PATIENT WAS RESPONSIBLE FOR THE BALANCE AT THE TIME OF THE APPOINTMENT, AN IOU IS BEING EXTENDED AT THE PATIENT'S REQUEST.

[Patient's Signature]

[Date]

DEAR PATIENT: PLEASE DETACH THE IOU INVOICE AT THE DOTTED LINE AND SEND THE BOTTOM PORTION ALONG WITH YOUR PAYMENT.

IOU-INVOICE (PAYMENT FORM)

Patient's Name: _____

Patient's Acct # : _____

IOU Amount: _____ Amount Enclosed: _____

Check # : _____ Date: ____/____/____

PLEASE RETURN THIS FORM WITH PAYMENT TO:

NEUROCARE CENTER, LLC

8815 CENTRE PARK DR. SUITE 220
COLUMBIA MD 21045

Please fax us at (732) 873 3378 with updated/changed insurance information, or if you have questions.

ID # : _____ Group # : _____ Subscriber's Name: _____

Name of *Secondary* Insurance Company (if any): _____

ID # : _____ Group # : _____ Subscriber's Name: _____