MAGNIFICENT MINDS
NEUROLOGY CENTER
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Board Certified in Adult and Child Neurology
Board Certified in Clinical Neurophysiology, FABPN
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Patient Name: _____ D.O.B. _____

BILLING CONTACT FORM

Please provide full information for the individual responsible for billing. Unless otherwise specified in this form, bills will be sent to the address on file and it will be your responsibility to forward the billing to the appropriate party.

□ **Please check here if the billing address is the same as the patient address.**

If billing address is different than patient address, please provide all requested information below.

Parent Name: _____

Billing Phone #: _____

Billing Address: _____
_____
_____

_____ _____
Parent/Guardian Name (Print) Parent/Guardian Signature