



INSURANCE COVERAGE WAIVER

I understand that my eligibility for coverage cannot be confirmed at this time.

I wish to receive medical services from New England Neurological Associates.

If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Signature of Patient/Legal Guardian: _____

EXENCION DE COBERTUAR DE SEGURO

Entiendo que mi elegibilidad de cobertura

Deseo recibir servicios medicos de New England Neurological Associates.

Si de determina que no soy elegible para la cobertura, entiendo que sere responsable del pago por todos servicios prestado.

Firma del paciente/Guardian Legal: _____

Riverwalk
354 Merrimack Street
Lawrence, MA 01843

Gateway Center
10 George Street, Suite 300
Lowell, MA 01852

Medical Arts Building West
168 Kingsley Street, Suite 1
Nashua, NH 03061

neneuro.com  
**354 Merrimack Street
Lawrence, MA 01843**

Doctor's Office Building
21 Highland Ave, Suite 12
Newburyport, MA 01950

**Northeast Rehabilitation
Hospital Outpatient Dept.**
70 Butler Street
Salem, NH 03079

Westford Commons
234 Littleton Road, Suite D
Westford, MA 01886

Phone for all locations:
(978) 687-2321
Fax for all locations:
(978) 722-7289