Patient Demographics Information

Patient's Name

 Last First Middle

Patient's Address:

City: State: Zip:



Phone numbers: Home: Work: Cell:



DOB: Age: Sex: SSN:



Marital Status: Email:



Primary Physician: Ph#: Referring Physician: Ph #:



Pharmacy:

In case of emergency, whom should be notified?

Relationship to patient: Tel Home



Medications Dose How Often

1.



2.



3.



4.



5.



6.



Authorization to Disclose Protected Health Information

1  , authorize Premier Neurology and Wellness Center to obtain/release my protected medical records.

Physician or individual:

Address:

Phone: Fax:



* **Imaging**

 Labs

 All Records

Signature of Patient or Legal Guardian: Date:



Printed Name of Patient or Legal Guardian: Date:



Important:

This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal health insurance portability & accountability act (HIPPA) privacy rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt form disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any discloser, dissemination, distribution or coping of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.

# Statement of Patient Financial Responsibility

Patient Name: DOB:

Here at Premier Neurology, the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Premier Neurology, for providing medical services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Premier Neurology, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature Date



Guarantor Signature Date



(If guarantor is not the patient)

# Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature Date



# Consent for Treatment and Authorization to Release Information

I hereby authorize Premier Neurology, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.

I further authorize Premier Neurology, to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment.

Patient/Guarantor Signature Date



## Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

The Practice will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature Date



## Self-Pay

I do not have health insurance and will be responsible for services rendered here at Premier Neurology. I agree to pay Premier Neurology, the full and entire amount of treatment given to me or to the above-named patient at each visit.

Patient/Guarantor Signature Date



# Motor Vehicle Insurance (PIP)

I do not have health insurance. I request my claims be submitted to my motor vehicle carrier. I understand I will be responsible for bills incurred by me in the event my PIP benefit exhausts or denies.

Patient/Guarantor Signature Date



Patient/Guarantor Signature Date



# Patient Contact Authorization / HIPPA

Patient Name: D.O.B:



While we prefer NOT to leave messages, we would like to ensure that your medical information is properly protected as required by HIPPA guidelines. By completing the following telephone contact information form, it will give us authorization to contact and leave messages with those listed on this form. We will NOT leave messages containing sensitive health related information.

Please list the names of all family or friends with whom you authorize us to leave messages relating to your medical care.

 1.

2.