North Central Neurology Associates, PC

Date _____ Referring Physician _____

PATIENT INFORMATION

Last Name _____ First _____ Middle _____

Street Address _____ City _____ State _____ Zip _____

Billing Address _____ City _____ State _____ Zip _____

Birthdate _____ Occupation _____ Primary Doctor _____

Employer _____ Employer Address _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Married _____ Divorced _____ Single _____ Widowed _____ Sex _____ Age _____

Social Security # _____ Driver's License # _____ State _____

Emergency Contact _____ Phone # _____

INSURANCE INFORMATION

Name of Insurance Company _____

Policy # _____ Group # _____ Effective Date _____

Subscriber's Name _____ DOB _____ Relationship _____

Additional Insurance - Company Name _____

Policy # _____ Group # _____ Effective Date _____

Subscriber's Name _____ DOB _____ Relationship _____

Primary Care Physician with Insurance Carrier _____

INSURED (if other than patient) / RESPONSIBLE PARTY / PARENT:

Name _____ DOB _____ Social Security # _____

Employer _____ Employer Phone # _____

Employer Address _____

PLEASE COMPLETE OTHER SIDE

CONSENT FOR TREATMENT - I consent to necessary treatment including drugs, medicine, performance of operations, or other studies that may be used by the attending physician, nurse practitioner, or his nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION - I authorize North Central Neurology Associates, PC to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to North Central Neurology Associates, PC of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not exceed the charges for these services. I understand that I am financially responsible to North Central Neurology Associates, PC for charges not covered by this assignment. I authorize the refund of overpaid insured benefits where my coverage's are subject to coordination of benefits.

GUARANTEE OF ACCOUNT - For services furnished by North Central Neurology Associates, PC I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption and the State of Alabama and agree to pay if necessary, all cost of collection, including attorney's fees.

COPAYS AND INSURANCE - Copays are due at time of service. We will bill your insurance out of courtesy to you, but it is your responsibility to be sure you are covered for this visit.

Signature: _____ Date: _____