

PATIENT INFORMATION SHEET

Name: _____ Age: _____ Birth Date: _____

S.S. No.: _____ Name of Parent if Minor: _____

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

Residence Street: _____ City: _____ State: _____ Zip: _____

Mailing Address: Street: _____ City: _____ State: _____ Zip: _____

Family Physician: _____ Referring Physician: _____

PATIENT'S (OR PARENT/GUARDIAN) EMPLOYER INFORMATION

If parent, name: _____ Social Security #: _____ Occupation: _____

Employed by: _____ Work Phone #: _____ Date of Birth: _____

Company Address: Street: _____ City: _____ State: _____ Zip: _____

SPOUSE (OR PARENT/GUARDIAN'S SPOUSE) INFORMATION

Name of Spouse: _____ Social Security #: _____ Occupation: _____

Employed by: _____ Work Phone #: _____ Date of Birth: _____

Company Address: Street: _____ City: _____ State: _____ Zip: _____

Are you currently a resident in a skilled nursing facility/nursing home?(circle one) Yes No

Length of residency? (circle one) Short term Long term

EMERGENCY INFORMATION

RELATIVE NOT LIVING WITH YOU

Name: _____ Phone #: _____

Address Street: _____ City: _____ State: _____ Zip: _____

Relationship: _____

INSURANCE INFORMATION

Circle one: **FOR MOTOR VEHICLE** **WORKMAN'S COMP** **HEALTH INSURANCE**

Date of Accident: _____ Company's Name: _____

Company's Address: Street: _____ City: _____ State: _____ Zip: _____

•••••**VERY IMPORTANT ******* Claim No.: _____

Policy: _____ Adjuster Name: _____

Adjuster Phone #: _____ State, if other than PA: _____

HEALTH INSURANCE INFORMATION FOR ALL PATIENTS

a) Primary Insurance Co.: _____

Company's Address: Street: _____ City: _____ State: _____ Zip: _____

Subscriber's Name: _____ Date of Birth: _____ Social Security #: _____

Relation to patient (circle one): Self Spouse Mother Father Guardian

b) Secondary Insurance Co.: _____

Company's Address: Street: _____ City: _____ State: _____ Zip: _____

Subscriber's Name: _____ Date of Birth: _____ Social Security #: _____

Relation to patient (circle one): Self Spouse Mother Father Guardian

Date: _____ Patient: **X** _____

(Or Authorized Representative)

AUTHORIZATION AND AGREEMENT FOR PAYMENT

I understand that I am fully responsible for all fees payable to **NEUROLOGY ASSOCIATES OF MONROE COUNTY** for medical treatment rendered to me or a member of my family.

I authorize payment of all medical benefits for services rendered by **NEUROLOGY ASSOCIATES OF MONROE COUNTY** to **NEUROLOGY ASSOCIATES OF MONROE COUNTY**.

In the event that I am denied insurance coverage, or my information provided is incorrect, invalid and/or missing I will make arrangements to pay bills within thirty (30) days.

I understand that I am entering into a contractual relationship with **NEUROLOGY ASSOC. OF MONROE COUNTY** and my physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by **NEUROLOGY ASSOC. OF MONROE COUNTY** and my physician, I and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of malpractice against **NEUROLOGY ASSOC. OF MONROE COUNTY** and my physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I and/or my representative agree to use ABMS board-certified expert medical witness(es) in the same or similar specialty as my physician. Furthermore, I agree that these expert witnesses will adhere to the guidelines and / or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case. In further consideration for this, **NEUROLOGY ASSOC. OF MONROE COUNTY** and its physicians agree to the same stipulations.

By my signature, I certify that I have read and understood the above or that all the above provisions have been fully explained to me.

Date: _____

Patient: _____
(Or Authorized Representative)

ATTENTION MEDICARE PATIENTS

NAME OF PATIENT: _____

(OR AUTHORIZED REPRESENTATIVE)

PATIENT'S MEDICARE CARD #: _____

I request that payment of authorized Medicare benefits be made on my behalf to **NEUROLOGY ASSOCIATES OF MONROE COUNTY** for any services furnished me by that physician/supplier who accepts assignment. I authorize any holder of medical information about me, to release to the Center for Medicare and Medicaid Services (CMS/formerly HCFA) and its agents any information needed to determine these benefits payable for related services. I also understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits apply.

MEDIGAP AUTHORIZATION STATEMENT

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to be made to the party who accepts assignment.

Date: _____

Patient: X _____
(Or Authorized Representative)