NEUROLOGY SERVICES, INC.
www.neuro-doc.com

P.G. Bernad, MD, MPH, FACP
Medical Director

PATIENT UPDATE

Today Date:_____

PT:LAST_____**FIRST**_____**MI**_____

PT'S SSN #: _____**PT'S DOB**: _____**AGE**: _____ **SEX**: M or F **STATUS**: S M D W

HOME ADDRESS: _____
(# Street) (City) (State) (Zip)
PT'S (H) PHONE: ( )_____ **PT'S (W) PHONE**: ( ) _____ EXT_____
PT'S CELL PHONE ( )_____ **PT'S EMPLOYER:** _____
LOCAL PHARMACY NAME/PHONE NUMBER:_____

PT EMAIL:_____ REFER BY_____
EMERGENCY CONTACT W/CELL #:_____

Guarantor Information (Responsible Party)

LAST NAME: _____ **FIRST NAME**: _____ **MI** ____

HOME ADDRESS: _____
(# Street) (City) (State) (Zip)
HOME PHONE: ( )_____ **WORK PHONE**: ( ) _____ EXT_____
CELL PHONE: ( )_____RELATIONSHIP TO PATIENT: _____
DOB:_____**SOCIAL SECURITY NO.** _____

INSURANCE INFORMATION (FOR PLANS WE PARTICIPATE WITH ONLY)

PRIMARY INSURANCE: _____

POLICYHOLDER'S NAME: _____ **DOB:**_____ **SSN:**_____

POLICYHOLDER'S ADDRESS: _____
(if different from patient/guarantor – required by ins co)
POLICY NUMBER: _____ **GROUP NUMBER**:_____

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER_____

SECONDARY INSURANCE (ONLY IF WE PARTICIPATE):_____

POLICYHOLDER'S NAME: _____ **DOB:**_____ **SSN:**_____

POLICYHOLDER'S ADDRESS: _____
(if different from patient/guarantor – required by ins co)
POLICY NUMBER: _____ **GROUP NUMBER**:_____

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER_____

Authorization for Assignment of Benefits / Release of Information/ Financial Agreement

I authorize Neurology Services, Inc to apply for benefits from my insurance carrier and further authorize payment directly to Neurology Services, Inc. for the medical and/or mental health benefits, if any, otherwise payable to me for services rendered by Neurology Services, Inc. I understand that this service is available for health plans that Neurology Services, Inc. participates and will only be submitted for the primary insurance plan unless my primary plan is Medicare. I further authorize the release of medical/mental health information required by my insurance carrier or its designated review agent, required for payment, or (if applicable) my employer's worker's compensation insurance carrier in order to determine benefits to which I may be entitled, or to designated agents of Neurology Services, Inc. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or by the insurance carrier at any time in writing. **I hereby assume financial responsibility for and agree to make payment in full to Neurology Services, Inc**. **for all charges for services provided to the above-named patient not otherwise authorized or paid by my insurance carrier**. Payment is to be made within fourteen (14) days as statements are presented with settlement in full, or payment arrangements to be made with Neurology Services, Inc. I certify that the information given is true, accurate, and complete to the best of my knowledge, and further authorize Neurology Services, Inc. to investigate any and all information given concerning this or related claims

Policies and Procedures

LATE CANCELLATIONS/ MISSED APPOINTMENTS POLICY:

If you cancel your appointment without 24 (twenty-four) hour notice, or do not show for a scheduled appointment, you will be charged $50 for office visit, $150 for tests scheduled. To avoid this charge, you must leave a message on our voicemail which is time stamped

FEES:

At the time of your visit, we will be glad to discuss our fee structure for specific diagnostic/treatment procedures. You will be expected to pay your deductible and/or co-payment at the time of each visit. We will bill your primary insurance carrier if you have signed the authorization section below and if we participate with health plan.

INSURANCE COVERAGE:

We strongly urge you to know what deductibles, co-payments, visit and/or benefit limitations, authorization requirements, and exclusions your plan may include. If we have submitted a claim to your carrier, we will receive an Explanation of Benefits (EOB) from the plan. Neurology Services, Inc. will use this information to determine your responsibility for full payment. You should review the EOB that is sent to you by the plan carefully. If you feel that they have made in error in administering your benefits, please call them directly to have it corrected. We will use the EOB as a final determination of benefits available. **HMO PATIENTS ARE RESPONSIBLE TO OBTAIN THE REQUIRED REFERRAL FROM YOUR PCP PRIOR TO EACH VISIT.**

PRIVACY NOTICE: My signature below confirmed that I am aware of Neurology Services, Inc. Notice of Privacy Practices.

NOTIFICATION OF CHANGES:

We expect that you will notify our office immediately of changes in the following information:

- Name, address, or phone number changes
- Change in Insurance Carrier
- Change in Primary Care Physician
- Change in marital status

RETURNED CHECKS:

There is a $25 (Twenty-five) charge for any returned check from your bank.

I understand and agree to abide by the above policies and procedures:

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

PLEASE REMEMBER TO SIGN