CHICAGO NEUROSCIENCE INSTITUTE

Private Health Insurance or Medicare Information	Patient Personal Injury Insurance Information
Policy Holders Name:_____ Social Security Number:_____ Insurance Companies Name:_____ Insurance Phone #:_____ Policy or Group #:_____ Medicare #:_____	Date of Injury:_____ Name of Insurance:_____ Address:_____ City:_____State:_____Zip:_____ Phone #:_____ Claim #:_____ Policy Holder:_____ Claim Adjuster:
Private Secondary Insurance Information	**Third Party Insurance Company Information**
Policy Holders Name:_____ Social Security Number:_____ Insurance Companies Name:_____ Insurance Phone #:_____ Policy or Group #:_____ Medicare #:_____	Name of Insurance Company:_____ Address:_____ City:_____State:_____Zip:_____ Phone #:_____ Claim #:_____ Policy Holder:_____ Claim Adjuster:
Name of Attorney: _____ **Address:**	**Phone: _____ Fax: _____** **Notes:**

WORKERS COMPENSATION

Date of Injury:_____ Insurance Company Name:_____ Address:_____ City:_____State:_____Zip:_____ Phone #:	Claim #:_____ Attn:_____ Employer at the time of injury:_____ Address:_____ City: State: Zip:

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with_____
Name of your Insurance Company

And assign directly to Chicago Neuroscience Institute, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for al charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Insured/Guardian: Date:

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Chicago Neuroscience Institute for any services furnished to me. I authorize any holder of medical information needed to determine these benefits of the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.5

Beneficiary Signature: Date: