PATIENT REGISTRATION FORM

Name: ____

Date of Birth: ______/_____/_______ SSN: _______-______-___________ Gender: _____________

Address: ____

Home Phone: (___) ______-________ Cell: (____) ______-________Work: (___) ______-__________

Email Address: ____

Ethnicity: ________________ Marital Status: _______________ First language: ________________

*Preferred pharmacy and phone number: ____

Primary Care Physician: ___________________________ PCP Phone #: (_____) _______-_________

Employer/Occupation:____

RESPONSIBLE PARTY INFORMATION

( ) Check here if same as above.

Name:____

Address:____

City:____State:__________Zip:_____________

Home #:________________ Cell #:______________ Employer/Occupation: __________________

Email: ____

REFERAL REQUIREMENT

I understand that depending on my insurance, I may have an obligation to obtain a referral from my Primary Care Physician prior to making an appointment. I acknowledge that if I do not have a required referral for today's visit, I am responsible for the services rendered should this be denied by my insurance company. If you are unsure if you will need a referral or authorization, you will need to contact your insurance carrier prior to your visit.

Signature: ____ Date: ____________________

Referring Physician Name: ___________________________ Tel:_____________ Fax:____________

Address:____

City:______________________________ State: _______________ Zip:____________________

EMERGENCY CONTACT / SPOUSE / GUARDIAN

Name:____

Address: ____

Home Phone: (___)_____-_____ Cell Phone: (___)_____-______Work Phone: (___)_____-______

PRIMARY INSURANCE INFORMATION

Primary Insurance: ____

Policy Holder's Name: ____

Policy Number/Member ID____

Group Number: ____

Policy Holder's DOB: _____/_______/______ Policy Holder's Phone: (_____)_______-__________

SECONDARY INSURANCE INFORMATION

Secondary Insurance: ____

Policy Holder's Name: ____

Policy Number/Member ID#: ____

Group Number: ____

Policy Holder's DOB: _____/_______/______ Policy Holder's Phone: (____) _______-_________

CONSENT TO TREAT AND PAYMENT AUTHORIZATION

With my signature below, I voluntarily give consent for myself and/or my child to be examined and treated by the clinicians of **Neurovations Clinic**. I authorize my insurance company(s) to pay benefits directly to **Neurovations Clinic** and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

Signature: ____ Date: ______________________

MEDICAL RECORDS RELEASE AND INSURANCE ASSIGNMENT

Initial _____ I authorize Neurovations Clinic to release to any third party (such as insurance company/govt agency) any medical information and/or records concerning diagnosis and treatment when requesting for use in determining claim for payment.

Initial _____ I authorize Neurovations Clinic to release records to healthcare providers involved in my continuing care and treatment.

Initial _____ I authorize the release of my medical records to Neurovations Clinic to release them from all responsibility and/or liability that may arise from authorization.