NEUROVATIONS CLINIC

PATIENT REGISTRATION FORM

Name: _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____ Gender: _____

Address: _____

Home Phone: (___) _____-_____ Cell: (____) _____-_____Work: (___)_____-_____

Email Address: _____

Ethnicity: _____ Marital Status: _____ First language: _____

Preferred pharmacy name and phone number: _____

Primary Care Physician: _____ PCP Phone #: (_____) _____-_____

Referral Requirement

I understand that 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.

Please note that the Patient can be accompanied by one person in the exam room to ensure proper treatment and less distractions for the provider and the patient.

Signature: _____ Date: _____

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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: (_____) _____-_____

NEUROVATIONS CLINIC

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.

Please note that the Patient can be accompanied by one person in the exam room to ensure proper treatment and less distractions for the provider and the patient.

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.

Signature: _____ Date: _____

2200 Lee Rd Phone 321-285-2369 or 321-972-1079 Fax 866-950-0261