

Patient Name _____ M/F _____ Age _____ Birthdate _____ SSN _____
Mailing Address _____ Zip _____
Street Address _____ Zip _____ Phone # _____

MEDICINE ALLERGIES _____

REFERRING DOCTOR: _____ *You may call my cell phone & leave msg:* Y N Cell# _____

Father's Name _____ Birthdate _____

Father's Address _____ Zip _____ Father's Home Phone _____

Father's SSN _____ Father's Employer _____ Work Phone _____

Mother's Name _____ Birthdate _____

Mother's Address _____ Zip _____ Mother's Home Phone _____

Mother's SSN _____ Mother's Employer _____ Work Phone _____

WE WILL BILL YOUR INSURANCE FOR YOU, PLEASE PROVIDE COMPLETE & ACCURATE INFORMATION

Primary Ins Company _____ **Secondary Ins Company** _____

Address _____ Address _____

Subscriber _____ B/D _____ Subscriber _____ B/D _____

Is insurance through employer? _____ Group # _____ Insurance through employer? _____ Group # _____

ID# _____ ID# _____

PREAUTHORIZATON PHONE# _____ PREAUTHORIZATION Phone # _____

Insurance Company Phone# _____ Insurance Company Phone# _____

Is This a Motor Vehicle Accident? _____ **Part of Body Injured** _____ **Date of Accident** _____

Insurance Company Name & Address _____

Insured's Name _____ Claim # _____

Claims Examiner Name & Phone Number _____

Is an Attorney Involved? _____ If YES, Name and Address of Attorney _____

I assign PAYMENT OF MEDICAL BENEFITS to NEUROLOGICAL ASSOCIATES. I give permission to NEUROLOGICAL ASSOCIATES to disclose my personal data for treatment, account balance resolution, and other healthcare operations to appropriate agencies. I agree that I am responsible for and will pay any and all charges that are not covered by insurance and all third party agency fees that may be incurred in the process of the collection of my claims. Any phone numbers provided for means of contact may be used and shared with third party collection agencies. This information is not sold. I am aware finance charges are assessed on overdue accounts over 90 days and a \$25 minimum charge is assessed for insufficient funds on personal checks.

Signature of Responsible Party _____ Date _____