

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip/State \_\_\_\_\_

Home Phone # \_\_\_\_\_ Street Address \_\_\_\_\_

SS# \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

Marital Status: **S M D W** Spouse' Name \_\_\_\_\_ Spouse SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse Work Phone \_\_\_\_\_

**MEDICINE ALLERGIES** \_\_\_\_\_

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

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

**Primary Ins Company** \_\_\_\_\_

Subscriber is (Circle one):    Self    Spouse    Parent

Subscriber's Name: \_\_\_\_\_

Subscriber's Birthdate: \_\_\_\_\_

Ins. ID# or SS# is: \_\_\_\_\_

Group#: \_\_\_\_\_

Is Ins. Through Employer?    Yes    No

If Yes, Employer Name: \_\_\_\_\_

**Secondary Ins Company** \_\_\_\_\_

Subscriber is (circle one):    Self    Spouse    Parent

Subscriber's Name: \_\_\_\_\_

Subscriber's Birthdate: \_\_\_\_\_

Ins. ID# or SS# is: \_\_\_\_\_

Group#: \_\_\_\_\_

Is Ins. Through Employer?    Yes    No

If Yes, Employer Name: \_\_\_\_\_

**HAVE RECEPTIONIST COPY YOUR CURRENT INS CARD     Card Copied**

**Is This a Motor Vehicle Accident?** \_\_\_\_\_

**Date Of Accident** \_\_\_\_\_ **Claim #** \_\_\_\_\_

Part of Body Injured \_\_\_\_\_

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Claims Examiner \_\_\_\_\_

Auto Insurance Phone # \_\_\_\_\_

Insured's Name \_\_\_\_\_

**Is This a Workers Comp Injury?** \_\_\_\_\_

**Date of Accident** \_\_\_\_\_ **Claim #** \_\_\_\_\_

Part of Body Injured \_\_\_\_\_

Ins Carrier \_\_\_\_\_

Address \_\_\_\_\_

Claims Examiner \_\_\_\_\_

Work Comp Phone # \_\_\_\_\_

Employer at Time Of Accident \_\_\_\_\_

**IS AN ATTORNEY INVOLVED?**     No     Yes-ATTY: \_\_\_\_\_ Phone# \_\_\_\_\_

I assign PAYMENT OF MEDICAL BENEFITS to NEUROLOGICAL ASSOCIATES. I authorize Neurological Associates to release personal data for treatment and/or PHI for account balance resolution, and other healthcare operations to appropriate agencies. I agree I am responsible for and will pay any and all charges 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 of .8% are assessed on overdue accounts over 90 days and a \$25 minimum charge is assessed for insufficient funds on personal checks.

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_