

Name _____ Date _____

Email address _____

Sex: M F Birthdate: _____ Marital Status _____ SSN: _____

Address: _____ City _____ State _____ Zip _____

Home Phone Number _____ Work phone number _____

Cell phone number _____

Responsible Party _____ Relationship to Patient _____

Responsible Party Employer _____

Responsible Party Birthdate _____

Parent or Legal Guardian _____ Address _____

City _____ State _____ Zip _____ Contact Number (s) _____

Patient's Employer _____ Contact Number _____

TDL# _____ Emergency Contact _____

Emergency Contact Relationship _____

Emergency Contact Number(s) _____

Primary Insurance Information

Name of Insurance Company _____ (give card to Receptionist)

Address for claims _____ City _____ State ____ Zip _____

Insured's Full Name _____ Insured's Date of Birth _____

Relationship of Patient to Insured _____ Group # _____ Policy ID _____

Note if your card indicates you are a member of Beech Street _____,

First Health _____, or PHCS _____

Secondary Insurance Information

Name of Insurance Company _____ (give card to Receptionist)

Address for claims _____ City _____ State ____ Zip _____

Insured's Full Name _____ Insured's Date of Birth _____

Relationship of Patient to Insured _____ Group # _____ Policy ID _____

Note if your card indicates you are a member of Beech Street _____,

First Health _____, or PHCS _____

For Office Use Only

Account Number _____ First Date of Service _____

TREATMENT AUTHORIZATION

Patient Name: _____ Date: _____
(Check and sign the applicable paragraph)

____ I authorize Bellaire Neurology, PA to examine, diagnose and treat me. I authorize and give Bellaire Neurology, PA consent to submit specimens (blood, urine, tissue, etc.) to the laboratory (ies) of choice for analyses and study to include diagnosis for submission for payment to the insurance carrier for the named patient.

Signature of Patient Date _____

____ I hereby authorize Bellaire Neurology, PA to examine and treat _____ (name of patient). I authorize and give Bellaire Neurology, PA my consent to submit specimens (blood, urine, tissue, etc.) to the laboratory (ies) of choice for analyses and study to include diagnosis for submission for payment to the insurance carrier for the named patient

Signature of Parent/Guardian Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Bellaire Neurology, PA to release any information necessary to my insurance company (ies), including governmental health care insurer (such as Medicare and Medicaid) or other health care practitioners involved in the care of the named patient. I understand that I am giving this authorization only in the case of a subpoena or for the release of information necessary for the provision of continuity of care, to determine insurance benefits and the payment of any claims, and/or for all health plan procedures related to the evaluation of the quality and cost-efficiency of care.

Signature Date _____

RESPONSIBLE PARTY AGREEMENT

I do hereby acknowledge that I am the guarantor of this account and agree to pay for services rendered, including any supplies or pharmaceuticals that are provided to me in my treatment. If any charges are submitted to my insurance carrier by either Bellaire Neurology, PA or by a provider of healthcare services/products/ equipment which are ordered by my physician for the care of the named patient and these services are not covered medical services, I agree to pay for any balance deemed applicable according to my health insurance rules and regulations. I hereby agree that I am responsible for the payment of any co- payment, deductible and co-insurance and that I agree to make payment for these amounts at the time of service. If I am not covered by any insurance carrier, I agree to pay for services rendered at the time of service.

Signature Date _____

MEDICARE/ MEDICAID AUTHORIZATION

I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to Bellaire Neurology, PA for any services furnished by my physician to the named patient. I understand my signature requests that payment be made directly to the provider of care and that the provider agrees to accept the charge determination of the Medicare/Medicaid carrier as the full charge, and that the insured patient is responsible only for the deductible, co-insurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare/Medicaid carrier. I attest that I am eligible for Medicare and/ or Medicaid coverage.

Signature Date _____