

ISLAND NEUROLOGICAL ASSOCIATES. P.C.

Thank you for choosing our office! In order to serve you properly, we need the following information. PLEASE PRINT. All information is protected and confidential. *Your privacy is important to us!*

Patient Information:

Name _____
Address _____
City, State, Zip _____
Phone Number _____
Male / Female (circle) Marital Status: S M D W
Date of Birth _____
Social Security# _____ / _____ / _____
Employer _____
Occupation _____
Work Phone _____
Address _____
Person to contact in case of Emergency:

Phone _____ Relationship _____
Referring Physician _____
Address _____
Phone# _____

Insurance Information:

Primary Insurance

Insurance _____
Address _____
City, State, Zip _____
Insurance Phone # _____
Name of Insured _____
Insurance ID # _____
Group # _____

Secondary Insurance

Insurance _____
City, State, Zip _____
Insurance Phone # _____
Insurance ID # _____
Group # _____

Work Related _____ Auto Accident _____
Patient is in Skilled Nursing Facility _____ Hospice _____
Name of Facility _____
Address of Facility _____
Phone # of Facility _____

IF INSURED IS DIFFERENT THAN THE PATIENT:

_____ Insured's D/O/B _____ Social Security # _____

I have received a copy of the Notice of Privacy Practices which describes how my protected health information is used and disclosed by this practice.

I authorize the release of all medical information necessary to process my insurance claims and that are pertinent to my medical care. I assign all medical benefits, including major medical benefits, to which I am entitled to the above-named physician or Island Neurological Associates, P.C. A photocopy of the assignment is to be considered as valid as the original.

X _____
Signature of patient (parent, if minor) Date

ABOUT FINANCIAL ARRANGEMENTS

Payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Visa, MasterCard, or Discover, We will be happy to assist you in the processing of your insurance claim form. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

Returned checks and balances older than thirty (30) days will be subject to additional collection fees. Charges may also be made for broken appointments, appointments canceled without 24-hour advance notice, or legal agency fees associated with accounts in collections.

We must emphasize that as medical care providers, our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services were rendered.

You must realize, however, that:

1. Your insurance is a contract between you, your insurance company, and/or your employer. We are not party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most insurance companies and, therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (i.e. 50% or 80%) or the usual, customary, and reasonable fees, as determined by most insurance companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees which bears no relationship to the current standard and cost of care for this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover.
4. Should your insurance company (for any reason) not reimburse us directly, or if we should not hear from this company in reference to a claim, you will be responsible for full payment.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions regarding the above information, or any uncertainty regarding insurance coverage, please do hesitate to ask us. We are here to help. It is also wise to speak to your insurance company directly regarding their specific policies towards such matters, such as deductibles, co-payments, out-of-network care, referrals and authorizations. It is your responsibility to know the terms of your insurance policy.

I am not being seen/treated for any condition related to any motor vehicle or work-related accident.

I have read all of the above information on this sheet. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health insurance status.

Patient Signature: _____ **Date:** _____