RESPONSIBLE PARTY (GUARANTOR)

Relationship to Patient _____

Guarantor Last Name _____ First Name _____ M.I. _____

Guarantor Address _____

City _____ State _____ Zip _____

Guarantor Home Phone _____ Guarantor Work Phone _____

Guarantor Employer _____ Address _____

City, State, Zip _____ Email _____

Guarantor Soc. Sec. # _____ Guarantor Birth Date _____ Gender M F

PATIENT INFORMATION

Patient Last Name _____ First Name _____ M.I. _____

Patient Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Emergency Phone _____ Ext. _____ Emergency Contact _____

Patient Soc. Sec. # _____ Patient Birth Date _____ Gender M F

Patient Marital Status S M D W Employer _____

Referring Physician _____

Primary Physician _____ Email _____

INSURANCE INFORMATION

Medicare or Primary Insurance _____

Address _____ City, State, Zip _____

Phone _____ Policy I.D. _____ Group # _____

Co-pay Amount _____ Policy Effective Dates: _____

Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child

Policy Holder Name _____ DOB _____ Policy Holder Soc. Sec. # _____

Secondary Insurance _____

Address _____ City, State, Zip _____

Phone _____ Policy I.D. _____ Group # _____

Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child

Policy Holder Name _____ DOB _____ Policy Holder Soc. Sec. # _____

PATIENT RESPONSIBILITY: I hereby confirm that all the information provided by me is accurate and understand that I will be responsible for any costs incurred due to fraudulent information. I have obtained all appropriate referrals and I understand that all professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn to over to collection for non-payment then the patient is responsible for the bill, the interest, and collection and reasonable attorney fees.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND RELEASE INFORMATION: I hereby authorize payment directly to Neurological Specialists of the Surgical and/or Medical benefits, if any, otherwise payable to me. I authorize the release of any medical or other information necessary to process this insurance claim.

NO SHOW POLICY: I understand that there will be a fee charged to me if I miss an appointment or if I cancel with less than 24 hours notice. I also understand that my insurance coverage may not pay this fee and that I will be responsible for it.

_____ _____

SIGNATURE (PATIENT OR PARENT IF MINOR) DATE

PERMISSION TO TREAT A MINOR (UNDER AGE OF 18): In the event of an emergency, and I am unable to be contacted, I give permission to the doctors, or the persons under their instruction, to treat my child in their office or hospital as required by the events of that emergency situation.

_____ _____

SIGNATURE DATE