



Patient Registration – Welcome To Our Office

Patient Information

Patient Legal Name Last _____ First _____ MI _____

Social Security # _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Email _____

Patient Phone _____ 2nd _____

Date of Birth ____ / ____ / ____ Age ____ Sex Female Male Martial Status (M, D, W, S)

Referring Physician _____ Primary / Family Physician _____

If not referred, how did you find out about us? _____

Do you reside in a Nursing Home Facility? yes no or Assisted Living Facility yes no

Name of Facility _____

Address of Facility _____ City _____ State _____ Zip _____

Employment Info.

Employer / Company _____

Employer's Address: _____

City, State, Zip _____

Employers Phone _____ Occupation _____

Emerg. Info.

In case of Emergency, Please Contact: _____ Phone (_____) _____

Relationship To You _____

Spouse Info.

Spouse's Name _____ Birth Date _____ Soc. Sec. # _____

Spouse's Employer _____ Occupation _____

Spouse's Employer's Address _____ Phone (_____) _____

City, State, Zip _____

Delinquent Accounts

Co-payments are due at time of service. There will be a \$15.00 service charge if co-payments are not paid at time of service.

A collection agency will take over a delinquent account if not paid in 45 days. If your account is placed with a collection agency, you will be responsible for all costs of collection. The rate charged by the collection agency is 50% of the total amount owed plus a \$25.00 placement fee. These additional charges will be the patient's responsibility. Should the account be moved to Small Claims, you will be responsible for all additional costs (Court costs, Attorney fees, Collection Agency fees, etc.).

Authorization Signatures

This certifies all information given on this form to be true and accurate and I understand and agree to Florida Neurology Group's Financial Policy.

X _____ Please print Guarantor Name X _____ Please sign Guarantor Name _____ Date _____

Credit Card

If paying by credit card, please sign and date below, then complete the the balance of the credit card information located in the bottom paragraph on the back of this form.

I plan to pay for today's visit with: Cash Check Visa Mastercard Discover

Patient's Signature _____ Date _____

Please Complete The Other Side

Lifetime Signature Authorization

Medicare B Signature Authorization for Services Starting Date: _____

I authorize any holder of medical or other information about me released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of Florida Neurology Group, P.L. needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Patient Signature _____ Date _____

Medical Records Release:

In order to process this and all future claims, or for any future applications which I may make to an insurance company for healthcare, I authorize Florida Neurology Group, P.L. to release my records to the requesting agent of the insurance company or to my employer if the claim is related to a workers' compensation claim. I permit a copy of this authorization to be used in place of the original.

Patient Signature _____ Date _____

This is a lifetime authorization and it may be revoked by me at anytime in writing.

Payment Agreement Conditions

For the self-pay patient:

I understand and acknowledge that I am responsible for full payment of services rendered to me by all healthcare providers of Florida Neurology Group, P.L. and understand and acknowledge that any amount(s) which are designated a "patient responsibility" are payable at the time the service is provided. Should any separate payment arrangement(s) be established as my responsibility that are not kept current, I agree to assume any necessary Fees involved in the collection of any remaining balance should it become delinquent.

Patient Signature _____ Date _____

For the patient with Insurance coverage:

I understand and acknowledge that Florida Neurology Group, P.L. will file a claim(s) for insurance payment(s) with only those insurance companies that Florida Neurology Group, P.L. participates as a provider. I agree to pay for any non-covered services, co-payment or deductibles which are considered as a "patient responsibility" under the conditions of my policy at the time the service is provided.

Should my insurance carrier later determine that additional costs are not covered under the conditions of my policy, and I am designated as the responsible party for such services, any remaining balance will be billed to me and I will pay the remaining balance upon receipt of billing. I agree to assume any necessary fees involved with the collection of this account should it become delinquent.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits for any services rendered to be paid directly to the provider or the party that accepts assignment.

Patient Signature _____ Date _____

If credit card, complete the following: Account # _____ Exp. Date (Mo/Yr) _____

I authorize Florida Neurology Group, P.L. to keep my signature on file and to charge my (Credit Card Type) _____ account as indicated above for the balance of charges not paid by insurance within 90 days and not exceed \$ _____ for (indicate one); _____ this visit only _____ all visits this year _____ recurring charges (on-going treatments) of \$ _____ every (frequency) _____ from (date) _____ to (date) _____. I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

Cardholder Name _____ Cardholder Signature _____ Date _____