MIDTOWN NEUROLOGY, P.C.
PATIENT INFORMATION AND DISCLOSURES

Name

First: ______________ Last: ______________ Middle: ______________

Gender
☐ Male
☐ Female

Phone

Home: ______________ Work: ______________ Mobile: ______________

Home Street Address: ______________

City/State/Zip: ______________

Social Security#: ______________ Birthdate: ______________ Email Address: ______________

Race : ______________ Marital Status: ☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Widowed

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Not Employed ☐ Student

☐ This is **NOT** a work related Condition, injury or symptom. ☐ This **IS** a work related Condition, injury or symptom.

Patient's Occupation: ______________ Employer Name: ______________

Employer Address: ______________

Emergency Contact : ______________ Relationship to you: ______________

Contact Phone : Home ______________ Work : ______________

Name of Primary Ins.Co ______________ Are you the Policy Holder? ______________

Name of Second Ins.Co ______________ Are you the Policy Holder? ______________

If policy holder is anyone other than the patient, please provide their Social Security Number and date of birth to the receptionist.

Please tell us how you heard about our practice: ______________

PAYMENT / COPAYMENT IN FULL IS EXPECTED AT THE TIME WHEN SERVICES ARE RENDERED. PLEASE PROVIDE YOUR INSURANCE CARD(S) AND IDENTIFICATION TO THE RECEPTIONIST FOR VERIFICATION.

Authorization to Release Information: I hereby authorize Midtown Neurology, PC to release any medical or other information to my insurance company to ensure payment.

Assignment of Benefits: I hereby authorize payment of medical benefits to Midtown Neurology, PC. I understand it is my responsibility to inform this office of any change in my insurance coverage.

Responsibility of Patient: I do hereby expressly guarantee payment in full on any and all claims and charges in consideration for medical services rendered or to be rendered to the patient. All delinquent accounts will be subject to payment of costs of reasonable collection fees and attorney fees. I understand that a $50.00 no show fee be applied to my balance for any appointments that are missed without rescheduling or canceling within 24 hours of my appointment.

I also understand that a $75.00 no show fee will be applied to my balance for any procedure that is missed without rescheduling or canceling within 48 hours of my appointment.

Privacy Practices Acknowledgement: I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature: ______________ Date: ______________