CONFIDENTIAL INFORMATION

PLEASE PRINT clearly - SIGNATURE required

TODAY'S DATE_____ **(FOR OFFICE USE ONLY)#**_____

PATIENT NAME:_____ _____ _____
First Middle Last

SOC SEC _____-_____-_____ **SEX**_____ **BIRTHDATE**_____-_____-_____**MARITAL STATUS M S W D**

ADDRESS_____ **APT #**_____**HOME PHONE ( )**_____

CITY /STATE_____ **ZIP**_____**CELL PHONE ( )**_____

EMPLOYER NAME_____**WORK PHONE ( )**_____**EXT**_____

EMPLOYER ADDRESS_____

INSURANCE COMPANY NAME_____**INSURED NAME**_____

RELATIONSHIP TO PATIENT_____**INSURED DATE OF BIRTH**_____

INSURED ID #_____**GROUP #**_____

FAMILY PHYSICIAN_____ **PHONE (_____)**_____

REFERRED HERE BY_____

PHARMACY NAME_____**ADDRESS**_____**PHONE ( )**_____

IN EMERGENCY, NOTIFY

NAME_____**RELATIONSHIP**_____--_____**PHONE ( )**_____

RESPONSIBLE PERSON (Responsible for billing)

NAME_____ **HOME PHONE ( )**_____

ADDRESS_____ **WORK PHONE ( )**_____

CITY/STATE/ZIP_____ **RELATIONSHIP TO PATIENT**_____

SOC SEC #_____ **DATE OF BIRTH**_____

EMPLOYER/ADDRESS _____**CITY/STATE/ZIP**_____

SPOUSE NAME_____**SPOUSE SOC SEC#**_____

EMPLOYER/ADDRESS_____

RELEASE OF INFORMATION AND BENEFITS STATEMENT FOR SIGNATURE

I authorize the release of medical information necessary to process my insurance claim. I understand these records may include psychological or psychiatric impairments, drug abuse, alcohol abuse, or human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS) or test results for HIV.

I authorize payment of insurance benefits (basic, major medical, HMO, PPO, Medicare or Medicaid) to the undersigned physician or supplier for the services described on the attached claim.

I acknowledge that I am responsible for payment of fees assessed for appointments not kept or canceled with less than a 24-hour notice.

I have been informed that the privacy policy of Memorial Neurological Association as it pertains to my health information is posted in the waiting room and a copy is available to me upon request.

DATE SIGNED _____ **SIGNATURE**_____

Pd: Patient Information 5-2007; Rev. 6-2007LL; Rev. 10-2009 KS