NEUROLOGY ASSOCIATES OF NWI, PC

Patient Information

Name:_____(Last, First, MI)
Address:_____City:_____State:_____Zip_____
Phone (_____)_____Work Phone (_____) _____ Cell Phone (____)_____
Date of Birth:_____ Social Security Number:_____
Race:_____ Language_____ Sex: M F (please circle)

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____☐ FT ☐ PT

Spouse or Parent's Name:_____ Employer_____ Work Phone(____)_____

Person to contact in case of emergency_____ Phone_____

Referring Doctor_____
Do you give us permission to run a PRESCRIPTION HISTORY REPORT? ____YES _____NO
Is this appointment due to an accident? ____YES____NO
If yes, date of accident_____ WORKER'S COMP_____AUTO_____OTHER_____

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____
Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

Insurance Information

Insurance Company_____
Grp #_____ ID#_____
Name of Insured_____DOB_____
Relationship to Patient _____
SSN#:_____
Name of Employer:_____ Work Phone: (____)_____

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Name of Insured_____DOB_____
Relationship to Patient _____
SSN#:_____
Name of Employer:_____ Work Phone: (____)_____

FEDERAL LAW ALLOWS US TO RELESASE INFORMATION TO THE PATIENT ONLY. YOU MAY DESIGNATE ANYONE YOU WISH US TO RELEASE INFORMATION TO BY LISTING THEIR NAME, PHONE NUMBER AND RELATIONSHIP BELOW. I AUTHORIZE YOU TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE FOLLOWING PEOPLE ONLY:

NAME_____RELATIONSHIP_____PHONE_____
NAME_____RELATIONSHIP_____PHONE_____
NAME_____RELATIONSHIP_____PHONE_____

FINANCIAL POLICY

The physician(s) at Neurology Associates of NWI,PC are committed to providing you with the best possible medical care. In order to assure this commitment, we have established the following collection and credit policy. ALL SERVICES ARE PAYABLE AT THE TIME OF VISIT. Please review the policy below and ask if you have any questions about our fees, this financial policy or your responsibility. As a courtesy to you, we will file all insurance claims for you. We must emphasize that as a medical provider, our relationship is with you and not your insurance company. Please review the following information:

- We accept cash, check, Visa/Master card.
- If payment is not received within 90 days, your account will be turned over to our collection attorney. Patient agrees to pay all costs incurred with collection of any past due account, including a monthly service fees, legal fees including court cost and attorney fees.
- If you check is returned due to non sufficient funds, a $30.00 charge will be assessed to your account. The NSF fee and the amount of the returned check must be paid prior to your next appointment.
- If we are contracted with your insurance company, payment at time of service will be determined by the insurance company rules which may include copays, deductible and any non covered serves. It is the patient's responsibility to check with their insurance company or employer regarding their policies, medical coverage issues or pre-certification requirements.
- If you have secondary insurance, upon request, we will file a claim as a courtesy for you as along as the necessary information is provided to us.
- HMO-You must have a referral from your primary care physician. MEDICAID-If you have a spend down, you are responsible for that amount.
- PERSONAL INJURIES (AUTO, LIABILITY): Must be paid at time of service. If requested, we will file your liability insurance for you. We do not accept assignment or negotiated fees for attorney cases involving personal injuries. Our office will supply you with the appropriate information for you to file with your attorney. You will be responsible to pay all charges at the time of service. WE DO NOT ACCEPT disputed auto accidents.
- WORKER'S COMPENSATION: Your must have prior authorization from either your employer or the workman's compensation carrier before an appointment can be made. WE DO NOT ACCEPT disputed worker's compensation.
- If you have diagnostics testing at a hospital, you will receive a bill from our office for the professional component and a bill from the hospital for the technical component of the testing. Please supply our office with your insurance or billing information.
- If you do not show for your appointment and you do not call within 24 hours to cancel or reschedule, there will be a $25 charge for follow-up, $50 for testing and $75 for new patients.

If you cannot meet these credit terms, please contact the billing department in advance to determine if payment arrangements can be made. I have read and understand the financial policy of Neurology Associates of NWI, PC.

I HEREBY GIVE MY CONSENT FOR TREATMENT AND AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. I UNDERSTAND THAT REGARDLESS OF MY INSURANCE, I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR SERVICES RENDERED. HOWEVER, IF MY INSURANCE OR ATTORNEY RECEIVES OR SENDS ME PAYMENT FOR SERVICES RENDERED BY DR. RICHARD H. SILBERMAN/NANWI, I WILL PROMPTLY MAKE PAYMENT TO DR. RICHARD H. SILBERMAN/NANWI. PATIENT IS RESPONSIBLE FOR ALL COLLECTION AND ATTORNEY FEES IF APPLICABLE. A PHOTOCOPY OF THE ASSIGNMENT IS CONSIDERED AS VALID AS THE ORIGINAL. THIS AGREEMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

PRINT PATIENT NAME_____DATE_____

SIGNATURE
(PATIENT/PARENT/GUARDIAN)_____DATE_____

EMPLOYEE/NEUROLOGY ASSOC SIGNATURE_____DATE_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

◯ I HAVE RECEIVED the Notice of Privacy Practices from Neurology Associates of NWI, PC

◯ I HAVE BEEN OFFERED A COPY AND REFUSED the Notice of Privacy Practices from Neurology Associates of NWI, PC.

SIGNATURE_____DATE _____

In lieu of patient signature, I, _____, a staff member of Neurology Associates of NWI, PC, state that _____has been given &/or offered our current Notice of Privacy Practices.

X_____DATE_____