THE NEUROLOGY FOUNDATION, INC. - Patient Registration Form

OFFICE USE ONLY
PT#_____
MD#_____

PATIENT INFORMATION Is this visit related to a work injury? Yes____ No____

Last Name _____First Name_____ Middle_____ Age_____

Address_____ City/State_____ Zip_____

Home Phone(____)_____Cell/other phone(____)_____Email address_____

Date of Birth___/____/____ Marital Status M S W D X Sex M F SS#XXX-XX-_____
(last 4 digits only)

Race: _____ (please pick one from below) Primary Language: _____
American Indian, Asian, Other Pacific, Black/African Amer. White, Hispanic, Other

Emergency Contact _____ Relationship_____ Phone(____)_____

FINANCIAL RESPONSIBILITY

Last Name _____First Name_____ Middle_____ Age_____

Address_____ City/State_____ Zip_____

Home Phone(____)_____Cell/other phone(____)_____Email address_____

Date of Birth___/____/____ Marital Status M S W D Sex M F SS# XXX-XX-_____
(last 4 digits only)

Employer Name_____ Work Phone(____)_____

PATIENT EMPLOYER

Name_____ Phone(____)_____

Patient's occupation_____ Start date_____ Present status_____

PRIMARY INSURANCE Name_____Policy #_____

Policyholder's Name_____ Relationship to patient_____ Date of Birth_____

Policyholder's employer_____ State_____ Phone(____)_____

SECOND INSURANCE Name_____ Policy #_____

Policyholder's Name_____ Relationship to patient_____ Date of Birth_____

Policyholder's employer_____ State_____ Phone(____)_____

REFERRING PHYSICIAN Name_____ Phone(____)_____

PRIMARY PHYSICIAN Name_____ Phone(____)_____

NAME OF PHARMACY **Name:** _____ **Adress:**_____

CONSENT

I,_____, consent to treatment necessary for the care of the above patient. I authorize the release of all medical information/records to referring/family physicians and to my insurance company, if applicable. I allow facsimile (fax) transmittal of my medical records if necessary.

SIGNATURE_____ PRINT NAME_____ DATE_____

THE NEUROLOGY FOUNDATION, INC. FINANCIAL POLICY

ABOUT OUR POLICY

This policy was designed to clearly outline all terms of our company financial policy. We are committed to providing first class consultation and professional services with fees that are comparable with those of other competent specialist in this area. In order to meet this commitment various administrative fees policies have been established to assist in controlling our costs. We do not want to cause financial hardship or embarrassment for any patient; therefore, feel free to discuss any aspect of our policy with our receptionist should you have any questions.

OUR COURTESY SERVICE

We will contact your insurer to obtain benefits information and make every effort to contact you in advance of your appointment to advise of any non covered services and/or any payment due from you at the time of service. Please not this information is subject to the accuracy and communication provided by insurer. We are not liable for such inaccuracies. Gathering of such data is a service provided to you as a courtesy; however, it is your responsibility to know the benefits and limits of your insurance coverage. No insurance covers everything 100%. Even with two or more insurance plans there may be amounts services not covered and for which the patient is responsible. Upon request, itemized statements shall be provided to you (the patient or guarantor) upon receipt of full payment and at no additional charge to you.

YOU ARE RESPONSIBLE FOR:

All payment of services rendered by The Neurology Foundation, Inc. Please note your insurance contact is between you and the insurance company; we are not a party to that contract. Our financial relationship is with you and not your insurance company. You are responsible to inform our office of any changes your insurance coverage as well as changes of address and telephone number should we need to contact you. Most insurers have timely filing limits which require submission of your claim within their time limits. We are not responsible for any information not received in time to submit your claims to your insurer in a timely manner. You are responsible to obtain any referrals and or authorizations required by your insurer prior to services being scheduled.

RULES FOR PLANS OF NONPARTICIPATION

You are ultimately responsible for our full charge for all services. Payment in full is expected at the time of service for all office visits. We shall submit on claim to your insurer for all other types of services. If we do not receive payment in full within 60 days of our bill date, we will bill date, we will bill you and expect payment within 30 days. Exception: Medigap carriers with automatic claims transfer.

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PLANS OF PARTICIPATION

We participate with the following insurance plans: Aetna Bluechip, Blue Shield of Rhode Island (excludes Major Medical), Cigna,, Harvard Pilgrim of Massachusetts, Massachusetts Medicaid, Medicare, Rhode Island Medicaid, Tufts, and United Health Care, Multiplan.

PAYMENT TERMS AND FEES

Payment is due at the time of service for office visits and within 30 days for other services. You are responsible for our full charge for all services. A nonpayment fee will be assessed per each date of service if payment is not received in full per the aforementioned. This fee is an addition to any professional fees incurred. To assist our patients with these terms, we accept the following methods of payment: cash, check, money order, debit cards, Visa, Mastercard, Discover, and American Express. Payment plans are available on an individual consideration basis and must be arranged prior to services being rendered. Fees: $20 nonpayment, $ 25 non sufficient funds, $ 35 for established patients who do not show for an appointment, $ 75 fee for new patients who do not show for an appointment.

ASSIGNMENT OF BENEFITS/ACKNOWLEDGEMENT

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or other carriers any information 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. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128 D of the Social Security Act and 31 U.S.C. 3801, 3812 provides penalties for with holding this information.) Regulations pertaining to Medicare assignment of benefits also apply. I allow fax transmittal of my medical records if necessary. I acknowledge full financial responsibility for services rendered. I agree to pay all reasonable attorney fees and/or court costs in the event of default of payment on my charges.

GUARANTOR SIGNATURE_____DATE_____/_____/_____
(person financially responsible for the patient named below)

PATIENT NAME_____DOB_____/_____/_____

WITNESS SIGNATURE_____DATE_____/_____/_____