Advanced Neurodiagnostic
Patient Information Form

Referring Physician:____

Patient Name____

Social Security Number ______-_____-_________ Birth Date_____/______/_____ Age:_____________ Sex: ___________

Patient Address:_____________________________________ Apt #: _________________

City:____ State:_________________ Zip__________________

Home Phone: _____________________Work Phone:_____________________ Cell Phone:_____________________

Employer: ____

Parent / Guardian Information

Is Patient a Minor: ______ (If Yes, Parent / Guardian Information and Signature Are Required)

Parent / Guardian Name:____

Parent / Guardian Social Security Number #:______-_____-________ Sex:________ Birth Date:______/______/_______

Relationship:____ Phone:___________________________

Address:____ Apt #: _______________

Employer: ____ Employer Phone:___________________________

Insurance Information

We will need your current insurance card and your driver's license or photo ID.

Primary Insurance

Insurance Name:____

Insurance ID# _______________________________ Group#:_____________________ Effective Date:___________

Insured's Name:_____________________________________ Relationship to Patient _______________________

Insured's Social Security #: ________-________-________ Insured's Birth Date:______/______/________ Sex _________

Insured's Employer:____

Secondary Insurance

Insurance Name:____

Insurance ID# ___________________________________Group#:____________________ Effective Date:__________

Insured's Name:____ Relationship to Patient ___________________

Insured's Social Security #: _______-______-________ Insured's Birth Date:______/______/_________ Sex ___________

Insured's Employer:____

Signature

I agree that the above is true to the best of my knowledge. Patient or Parent / Guardian

Signature:____Date_______________

Updated: 07/29/10

Advanced Neurodiagnostic Financial & Health Information Policy

Dear Patient
Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office.
We ask that all patients read and sign our Financial Policy prior to having an exam.

Cash Patients – payment for services are due at the time services are rendered.

Insured Patients – co-pays, deductibles, and/or co-insurances are due at the time services are rendered. We accept cash, checks, MasterCard, Discover or VISA for your convenience.

If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help speed things up. All insured patients are required to sign the assignment of benefits for payment from the insurance company.

Returned checks will be subject to a $25.00 fee.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event your account is turned over for collection, you will be responsible for any costs, including collection fees, interest, court costs, and other fees associated with collecting the debt.

Assignment of Benefits

I hereby guarantee payment of all charges incurred at the office of Advanced Neurodiagnostic. I hereby assign and direct to pay any and all benefits for medical services provided by ADVN directly to Advanced Neurodiagnostic. I hereby authorize the release of medical information required to process my claim.

I have read and agree to the terms spelled out in the financial policy and benefits assignment. I understand that this assignment applies to all services performed at Advanced Neurodiagnostic and is in effect until specifically revoked in writing. I further agree that I will ultimately be responsible for payment for all charges incurred should my insurance company fail to pay.

Patient's Signature: ____ Date: __________________________

Health Information Policy

I have received a copy of Advanced Neurodiagnostic (ADVN) Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state law.

I understand that ADVN may leave a message on my answering machine or with a third party regarding limited health information, pending appointments, and the time and place of scheduled appointments, or other healthcare related communications.

I understand that ADVN may disclose health information with other entities, such as my insurance company for purposes of treatment, payment, or business operations.

I authorize the following person(s) access to the use or disclosure of my health information. I understand that this authorization is in effect until specifically revoked in writing:

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Patient / Parent / Guardian Signature ____Date____________

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Updated on: 09/01/10