NEUROMEDICAL DIAGNOSTIC GROUP PATIENT INFORMATION SHEET

PATIENT INFORMATION (please print)

First Name: __________________________ Middle Initial: _____ Last Name: _____________________________________
Home Address: __________________________________ City: __________ ____ State: _____ Zip Code: ______________
Billing Address (if different): ____
Patients Age: ____________________________ Date of Birth: ____
Home Phone: __________________ Work Phone: _________________ Cell Phone: ______________________________
Preferred Contact #: ______________________________ Email Address: _______________________________________
Drivers License #: _________________________ State: ___________ Social Security: ______________________________
Sex: ❑ M ❑ F Marital Status: ❑ S ❑ M ❑ D ❑ W ❑ Other: ___________ How did you hear about us? ___________
Primary Care Physician: _________________________________ Primary Language: ______________________________
Race: _________________ Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino
Employer: _______________________________ Employer Phone: ______________ Occupation: __________________
Emergency Contact: _____________________________ Relationship: ______________ Phone: __________________
GUARANTOR/PARENT/INSURED INFO (SEND BILL TO):
Guardian Last Name (if Applicable):_____________________ __ First: __________________ __ Initial: ____________
Date of Birth: ______________ Social Security #___________________ Relationship: _________________________
Employer: _________________________ Address: ________________________________ Phone: __________________

INSURANCE INFORMATION

Primary Insurance: ____
Policy Holder Name: __________________________________ DOB: __________ Social Security#_________________
Billing Address: ____ City: ____________ State: _____ Zip: _____________
Group or Policy #: ______________ Cert. or Member #: _________________ _____ Local Union #: _________________
Co-Pay Amount: __________________ Policy Effective Dates: From: _____________ To: _______________________
Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other: _______________________________
Secondary Insurance: ____
Policy Holder Name: __________________________________ DOB: __________ Social Security #: ________________
Billing Address: ____ City: ____________ State: _____ Zip: _____________
Group or Policy #: ______________ Cert. or Member #: _______________________ Local Union #: _________________
Co-Pay Amount: __________________ Policy Effective Dates: From: _________________ To: __________________
Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other: ______________________________

PHARMACY INFORMATION

Pharmacy Name: _________________________ Address: __________________________ Phone: ____________________
Signature (Patient or Parent of Minor): ____ Date: _________________

FINANCIAL POLICY

AGREEMENT TO PAYMENT POLICY: I acknowledge that I received a copy of Neuromedical Diagnostic Group financial policy and agree to the terms off payment due.
AUTHORIZATION TO RELEASE INFORMATION: I authorize release of my medical record information, pursuant to applicable federal and state law, rules and regulations, to third party payers and other providers participating in my care, that agree to treat mu information in a confidential manner in accordance with all applicable feral, state and local laws. I further authorize any other individual or entity that has provided health care to me to release to Neuromedical Diagnostic Group, any and all of my medical records information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.
ASSIGNMENT OF BENEFITS: I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Neuromedical Diagnostic Group for any services provided to me and/or my dependents. I authorized any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.
GUARANTEE OF PAYMENTS: I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to NEUROMEDICAL DIAGNOSTIC GROUP are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amount in default.

______________________________________ ____________________________________
Patient Signature Date Responsible Party Relationship to Patient