

**NORTHWEST NEUROLOGY, LTD.**  
**INFORMATION FORM**

PATIENT NAME \_\_\_\_\_ Phone \_\_\_\_\_

(Please Print)

ADDRESS \_\_\_\_\_ CELL/WORK NUMBER \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PRIMARY CARE / REFERRING PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_ CO-PAY \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ SUBSCRIBER'S DATE OF BIRTH \_\_\_\_\_

SUBSCRIBER'S EMPLOYER: \_\_\_\_\_

SUBSCRIBER'S ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

PATIENT'S RELATIONSHIP TO INSURED: SELF \_\_\_\_\_ SPOUSE \_\_\_\_\_ CHILD \_\_\_\_\_ PATIENTS SEX: M F  
(Circle one)

SUBSCRIBER'S SOCIAL SECURITY # \_\_\_\_\_ \* (see below)

PATIENT'S SOCIAL SECURITY # \_\_\_\_\_ \* (see below)

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2NDARY INSURANCE: \_\_\_\_\_ GROUP # \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ ID # \_\_\_\_\_

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance payments. However, the patient is responsible for all fees, regardless of insurance coverage. This includes payment of services even though a liability action is involved and/or a denial of a workers' compensation claim. **It is our office policy not to get involved with auto accidents.** It is your responsibility to make payment and get reimbursed directly from your insurance company.

**Authorization for insurance company to pay benefits directly to physician:**

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Authorization to release medical information, regarding treatment, payment and healthcare operations:**

Signed \_\_\_\_\_ Date \_\_\_\_\_

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Medicare Authorization: I request that payment of authorized Medicare/Medigap benefits be paid directly to Northwest Neurology, Ltd., on my behalf for any services furnished to me by Northwest Neurology, Ltd. To the extent permitted by law, I authorize any holder of medical information to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

**Beneficiary Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**PATIENTS RIGHTS AND NOTICE OF PRIVACY PRACTICES:** I understand and acknowledge that I have been offered information regarding my rights and responsibilities as a patient and a copy of the Notice of Privacy Practices.

\_\_\_\_\_ INITIALS

**Emergency Contact:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

(Please print)

\* Please be aware that we still need your social security number on file. Even though the Insurance Companies have changed your ID number, if your claim is not paid, we cannot review it without your social security number which means that you would be responsible for your balance and would have to get re-imburement from your insurance company directly.

