TRI-STATE NEUROSCIENCE CENTER

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FOR OFFICE USE ONLY

REGISTRATION / INFORMATION FORM

☐ ESTABLISHED PATIENT ☐ NEW PATIENT	DATE OF APPT	TIME	DOCTOR
HISTORY NUMBER		ACCOUNT NUMBER	FICHE #

PLEASE PRINT

PATIENT

PATIENT'S FIRST NAME	MIDDLE NAME	LAST NAME	SEX ☐ M ☐ F	DRIVER'S LICENSE NO	AGE	DATE OF BIRTH MO. DAY YR
PATIENT'S STREET ADDRESS	APT. NO.	CITY		STATE		ZIP
PATIENT'S SOCIAL SECURITY NO.	RESIDENCE PHONE NUMBER ( )	RELATIONSHIP TO RESPONSIBLE PARTY ☐ SELF ☐ SPOUSE ☐ OTHER ☐ STEPCHILD ☐ CHILD		MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED		
PATIENT'S EMPLOYER & EMPLOYER'S ADDRESS		POSITION	HOW LONG	BUSINESS PHONE ( )		

SPOUSE OR PARENT

FULL NAME OF SPOUSE OR PARENT		SOCIAL SECURITY NUMBER		DATE OF BIRTH MO. DAY YR
RESPONSIBLE PARTY'S STREET ADDRESS	APT. NO.	CITY	STATE	ZIP
EMPLOYER OF RESPONSIBLE PARTY & EMPLOYERS ADDRESS		POSITION	HOW LONG	BUSINESS PHONE ( )

IMPORTANT PLEASE COMPLETE

NEAREST RELATIVE NOT LIVING AT SAME ADDRESS		RELATIONSHIP TO PATIENT	PHONE NUMBER ( )	
STREET ADDRESS	APT. NO.	CITY	STATE	ZIP

ACCIDENT INJURY ☐ YES ☐ NO DATE______ TIME______ WHERE HAPPENED? ☐ WORK ☐ HOME ☐ SCHOOL ☐ AUTO

COMPLAINT/INJURY

IF WORKMEN'S COMPENSATION FILL IN CLAIM NO. ________________

HOW WERE YOU REFERRED TO THIS CLINIC? ☐ EMPLOYER ☐ ADVERTISEMENT IN__________ ☐ OTHER__________

☐ DOCTOR ADDRESS DOCTOR'S PHONE NUMBER

INSURANCE

PATIENT'S PRIMARY INSURANCE COMPANY			PATIENT'S SECONDARY INSURANCE COMPANY		
CITY	STATE	ZIP	CITY	STATE	ZIP
POLICY NO (GROUP, CERT., SOC. SEC. NO.)	THIRD PARTY BILLING INFO. COMPANY NAME			POLICY NO. (GROUP, CERT., SOC. SEC. NO.)	
NAME OF POLICY HOLDER	ADDRESS			NAME OF POLICY HOLDER	
RELATIONSHIP TO PATIENT	CITY	STATE	ZIP	RELATIONSHIP TO PATIENT	

All charges incurred will be the responsibility of the patient, or that of his parents, guardian, or agent.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to Tri-State Neuroscience Center, Inc.

Signed ____

(Patient or Parent if Minor)

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Tri-State Neuroscience Center, Inc. to release any information acquired in the course of my examination or treatment.

Signed ____

(Patient or Parent if Minor)

(Continued on Back)

FINANCIAL POLICY

It is our hope that you will understand that our financial and billing policies are necessary to maintain vital health care service to our patients and the community. The following are our office's current financial policies which may be changed at any time without notice.

INSURANCE:

We will bill all PRIMARY insurance companies and any secondary insurances for our patients. Please provide us with complete and accurate insurance information, as well as any changes of address, telephone number or employer.

PRECERT:

Any tests requiring pre-certification from your insurance company is the patient's responsibility to notify insurance company or to make office personnel aware of the requirement.

PPO/HMO:

All require a referral/confirmation form prior to the office visit or the PPO/HMO will not pay for the services provided.

CO-PAYMENTS & DEDUCTIBLES:

Co-payments and deductibles will be collected prior to seeing the physician on the day of your appointment. All insurance companies require that the physician collect all co-pays and deductibles from the patient.

Your insurance coverage is a contract between you and your insurance company. You are still responsible for payment of your account.

MEDICARE:

We are a participant office. We will file your Medicare claims. We will also file your Medicare secondary insurance claims if you will provide us with the necessary information.

NON-INSURED:

Payment is due at time of service. If it is necessary to establish payment arrangements please contact our billing department prior to appointment.

AUTO ACCIDENTS AND PERSONAL INJURY:

All auto accident and personal injury patients are required to pay at time of service. An itemized statement will be given to patient upon request at time of payment.

STATEMENTS:

Itemized statements are issued monthly. Messages on the statement will indicate the status of your account.

I have read and understand this financial policy.

I understand my insurance coverage is a contract between myself and my insurance company and I agree to accept financial responsibility for payment of charges incurred.

Signature ______________________________ **Date** ____________________

(parent or guardian if patient is a minor)