ISLAND NEUROLOGICAL ASSOCIATES, P.C.

Patient Information:

Name

Address

City, State, Zip

Home Phone Number Cell Phone Number

Date of Birth **M / F** Gender

Social Security #

Employer

Occupation

Cell Phone

Email Address
Marital Status (circle) S M D W

Person to contact in case of Emergency

Phone # Relationship

Referring Physician

Address

Phone #

Primary Physician (If different than Referring Dr.)

Address

Phone #

Insurance Information:

IF INSURED IS DIFFERENT THAN THE PATIENT:

Insured D/O/B **SS #**

PRIMARY Insurance Company

Address

City, State, Zip

Phone #

Name of Insured Relationship

Insured ID # Group #

Patient's ID #

SECONDARY Insurance Company

Address

City, State, Zip

Phone #

Name of Insured Relationship

Insured ID # Group #

Is your visit related to:

Injury at Work _____
Auto Accident _____

I authorize the release of all medical information necessary to process my insurance claims and that are pertinent to my medical care. I assign all medical benefits, including major medical benefits, to which I am entitled to the above-named physician or Island Neurological Associates, P.C. A photocopy of the assignment is to be considered as valid as the original.

Patient Signature (parent, if minor) _____ Date_____

ABOUT FINANCIAL ARRANGEMENTS

Payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Visa, MasterCard, or Discover. We will be happy to assist you in the processing of your insurance claim form. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

Returned checks and balances older than thirty (30) days will be subject to additional collection fees. Charges may also be made for broken appointments, appointments canceled without 24-hour advance notice, or legal agency fees associated with accounts in collections.

We must emphasize that as medical care providers, our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services were rendered.

You must realize, however, that:

1. Your insurance is a contract between you, your insurance company, and/or your employer. We are not party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most insurance companies and, therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (i.e. 50% or 80%) of the usual, customary, and reasonable fees, as determined by most insurance companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees which bears no relationship to the current standard and cost of care for this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover.
4. Should your insurance company (for any reason) not reimburse us directly, or if we should not hear from this company in reference to a claim, you will be responsible for full payment.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions regarding the above information, or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help. It is also wise to speak to your insurance company directly regarding their specific policies towards such matters, such as deductibles, co-payments, out-of-network care, referrals and authorizations. It is your responsibility to know the terms of your insurance policy.

I acknowledge that if the provider is not paid in full at the time of service, or submits a claim to my insurance company, the provider is extending and otherwise deferring my time to pay the full charge for services rendered until the claim is paid by me or paid or denied by my insurance company. I further acknowledge that in the event my account remains past due and is referred to outside collection, such as a collection agency/law firm, (entities), I agree, to authorize said entities to communicate with my insurance company regarding my past due account and further authorize said entities to obtain and review my credit report.

I acknowledge that I will be charged a “no-show” fee for any appointments not canceled at least 24 hours in advance. The fee will be $25.00 for all visits and $75.00 for all tests.

I have read all of the above information on this sheet. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health insurance status.

Patient Signature: _____ Date: _____