**Neurology Consultants of Montgomery, P.C.**

**Patient Information Sheet**

Referred by Primary Care Physician

Social Security Number

First Name MI Last Name

Date of Birth Current Age Male Female Race

Marital Status: Married Single Divorced Widowed

Address City State Zip Code

Home Number Work Number Cell Phone Number E-mail Address

Occupation

Patient’s Employer Employer’s Address, City, State, and Zip Code

Are you a resident of a nursing home or assisted living facility? Yes No

If yes, which one?

Present Complaint? Why are you here today?

**Emergency Contact Name(s)**

Name Phone Number Relationship

Name Phone Number Relationship

PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOUSURE AND AGGREMENT TO PAY FOR PROFESSIONAL SERVICES.

I hereby authorize Neurology Consultants of Montgomery, PC to release any information necessary to process any insurance claim acquired in the course of my examination or treatment to allow a photocopy of my signature to be used to process my insurance claim. I claim, direct, and authorize my carrier to issue payment directly to Neurology Consultants, for any insurance benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier. Regardless of insurance benefits, in any, I understand that I am fully responsible for any and all fees incurred and I agree the above is legal and lawful debt. If it becomes necessary to forward this account to collections, I agree to be responsible for any/all collections cost, attorney fees and/or court fees. I realize that in extraordinary circumstances, some insurance companies will not pay for certain procedures(i.e. MRI’s, Ultrasounds). I understand that my insurance is filed as a courtesy and I am responsible for the bill.

I acknowledge that I have had an opportunity to review the Notice of Privacy Practices posted in the practices’ office and have been given an opportunity to retain a copy of the Notice.

**Patient/Responsible Party Signature** **Date**