EXPLANATION OF ACCIDENT OR INJURY

PATIENT NAME: _____

BODY PART: _____

HOW DID YOU GET INJURED?: _____

_____

_____

_____

WHEN DID THE ACCIDENT/INJURY/CHRONIC PAIN BEGIN?

_____ _____ _____

MONTH DAY YEAR

PLEASE CHECK WHETHER THIS WAS AN:

O ACCIDENT O INJURY O CHRONIC PAIN

WHERE DID THE ACCIDENT OR INJURY OCCUR?

_____

** IS THERE ANY LITIGATION PENDING OR ANY LEGAL ASPECTS OF THIS INJURY?

O YES O NO

IF ANSWERED YES, AGAINST WHO? _____

_____

SIGNATURE: _____

DATE: _____

D E

Neurology Consultants of Montgomery, P.C.
Patient Information Sheet

Referred by_____ **Primary Care Physician**_____

Social Security Number _____

First Name Mi Last Name

_____ _____ Male___ Female___ Race ____

Date of Birth Current Age

Marital Status: __ Married __ Single __ Divorced __Widowed Spouses Name_____

_____ _____ _____ _____

Address City State Zip Code

Home Phone Number Work Phone Number Cell Phone Number E-mail Address

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

Occupation _____

Please indicate who we may speak with regarding your PHI (protected health information)

_____

May we leave messages for you regarding your PHI or appointments: Yes___ No ___

Emergency Contact Name(s)

Relationship Home Phone Number Work Phone Number

Present Complaint -- Why are you here today?

Are **you a resident of a nursing home or an assisted living facility?** ____ **Yes** ____ **No**
If yes, which one? _____

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

I hereby authorize Neurology Consultants, 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 check(s) 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, if any, I understand that I am fully responsible for any and all fees incurred and I agree the above is a legal and lawful debt. If it becomes necessary to forward this account to collections, I agree to be responsible for any/all collection costs, attorney fees and/or court costs. I realize that in extraordinary circumstances, some insurance companies will not pay for certain procedures (i.e. MRI's or 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 practice's office and have been given an opportunity to retain a copy of the Notice.

Patient/ Responsible Party Signature **Date**

Your physician may refer you to Southern Imaging Specialists if you are having an MRI or Innerfit if you need physical therapy. Your physician may be a part-owner in these companies. If you would like to use another company, you are certainly free to do so- just ask the doctor or the nurse for a list of alternatives in the area. We respect your choice, and we will not treat you different if you choose another facility.