Neurologic Associates

1359 N Mount Auburn road
Cape Girardeau, MO 63701
P: 573-651-3188 | F: 573-651-3048

Last Name: _____ First Name: _____ Middle Initial: _____

Previous and/or Maiden Name (if minor – parents names): _____

Birth date: (MM/DD/YYYY) ____/____/____ Social Security Number: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ Caucasian or White ☐ Black or African American ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Home Phone: ( )_____ Cell Phone: ( )_____ Work Phone: ( )_____

Patient/Parent's Employer: _____ Phone Number: ( )_____

Spouse's Last Name: _____ First Name: _____ Middle Initial: _____ DOB: _____

Spouse's Employer: _____ Phone Number: ( )_____

Primary Insurance Company: _____ Plan Number: _____

Policy Holder: _____ DOB: _____ SSN: _____

Secondary Insurance Company: _____ Plan Number: _____

Policy Holder: _____ DOB: _____ SSN: _____

Have you seen one of our physicians previously in this specialty? Yes No If Yes, who?_____

Referring Physician: _____

Family Physician/Primary Care Provider: _____

_____ _____
Signature of patient or guardian Date

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including private insurance and any other health plan to: **NEUROLOGIC ASSOCIATES OF CAPE GIRARDEAU, INC.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignment to release all information necessary to secure payment.

_____ _____
Signature of patient or guardian Date

Neurologic Associates

1359 N Mount Auburn road
Cape Girardeau, MO 63701
P: 573-651-3188 | F: 573-651-3048

Confirmation/Consent of HIPAA

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this confirmation. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this confirmation/consent in writing at any time, except to the extent that you have taken action relying on this confirmation/consent.

Notice to Patients

We would like to make our patients aware of the changes in the Health Insurance Industry. Many of the major insurance companies have underwritten other insurance companies and/or health care plans. It has become a pyramid-type business and is not always clear-cut from policy to policy what they will or will not cover. Please know that whichever type of insurance you have, we will continue to file it as a courtesy to you, but your insurance is strictly a contract between you and that insurance company. Ultimately, any charges that are not paid by your insurance company are your responsibility. We greatly encourage you to contact your insurance company before receiving any type of medical treatment to make sure that the service and the provider are covered by your insurance plan.

I have read and understand the information, as provided to me above.

Patient Name (Please Print):_____

Signature of Patient/Responsible Party:_____

Date of Signature: _____

Neurologic Associates

1359 N Mount Auburn road
Cape Girardeau, MO 63701
P: 573-651-3188 | F: 573-651-3048

Family Release

Permission only granted for family listed below to schedule appointments or call on patient's behalf. This is not a medical records release.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that the specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). I authorize the release of this specific date. I also understand that this authorization may be revoked by the person giving the authorization by a written or dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation.

I understand that my health and the payment of my healthcare will not be affected if I do not sign this form. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I have read and understand this consent and I have signed it voluntarily and of my own free will.

_____	_____
Signature of Patient or Patient Executor	Signature of Witness (for office use only)