



**REGISTRATION FORM**

(Please Print)

**Patient's name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Patient's address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Patient's home phone:** \_\_\_\_\_ **Patient's cell phone:** \_\_\_\_\_

**Patient's employer:** \_\_\_\_\_ **Patient's work phone:** \_\_\_\_\_

**Sex:** male female **SSN:** \_\_\_\_\_ **Marital status:** single married divorced widowed

**Spouse's name:** \_\_\_\_\_ **Spouse's cell phone:** \_\_\_\_\_

**Spouse's SSN:** \_\_\_\_\_ **Spouse's date of birth:** \_\_\_\_\_

**Spouse's employer:** \_\_\_\_\_ **Spouse's work phone:** \_\_\_\_\_

**Nearest relative** (not in same household): \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Relative's home phone:** \_\_\_\_\_

**If patient is a child:**

**Responsible party's name:** \_\_\_\_\_ **Responsible party's SSN:** \_\_\_\_\_

**Patient's school:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Family physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Referring physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Primary insurance:** \_\_\_\_\_

**Policy number:** \_\_\_\_\_ **Group number:** \_\_\_\_\_

**Policyholder's name:** \_\_\_\_\_ **Policyholder's date of birth:** \_\_\_\_\_

**Policyholder's employer:** \_\_\_\_\_ **Patient's relationship to policyholder:** self spouse child

**Secondary insurance:** \_\_\_\_\_

**Policy number:** \_\_\_\_\_ **Group number:** \_\_\_\_\_

**Policyholder's name:** \_\_\_\_\_ **Policyholder's date of birth:** \_\_\_\_\_

**Policyholder's employer:** \_\_\_\_\_ **Patient's relationship to policyholder:** self spouse child

1. **Is this a work-related injury?** \_\_\_\_\_ yes \_\_\_\_\_ no
2. Have you engaged the services of an attorney in connection with your present illness/injury? \_\_\_\_\_ yes \_\_\_\_\_ no  
If "yes", name and address of attorney? \_\_\_\_\_  
If "no", do you anticipate retaining an attorney? \_\_\_\_\_ yes \_\_\_\_\_ no

**REGARDING FEES AND INSURANCE:** If you have insurance, we will provide you with an itemized receipt for services rendered in the office to forward to your insurance carrier to pay you directly. We complete insurance forms only for surgical fees and hospital services. It is our policy that fees for office visits are paid at the time of service. Any overpayment will be returned to the patient.

I understand that due to The NeuroMedical Center Clinic's specialized facilities and staff, charges may be in excess of "Usual, Customary, and Reasonable" insurance plan coverage that I may have. In such an event, unless a contractual agreement exists between The NeuroMedical Center Clinic and my insurance company, I agree that I will pay The NeuroMedical Center Clinic fees in full, even though the amount may be greater than what I may be entitled to receive from my insurance company. Any balance upon The NeuroMedical Center Clinic bill which is not expected to be reimbursed by insurance shall be payable by me. A fee of \$20 will be charged for all returned checks.

In the event The NeuroMedical Center Clinic charges for professional medical services are not paid timely, I understand that I will be legally responsible for all costs of collections, including 25% attorney's fees, court costs and legal interest.

I authorize The NeuroMedical Center Clinic staff to release any medical information necessary to process insurance forms. I further authorize The NeuroMedical Center Clinic staff to disclose or release any medical information requested by attorneys, physicians, insurance companies, employers, health care providers, or any other entity which may be concerned with payment of the charges incurred at The NeuroMedical Center Clinic. I further authorize payment of medical benefits to The NeuroMedical Center Clinic.

**REGARDING TREATMENT:** I hereby authorize the physician (s) at The NeuroMedical Center Clinic in charge of the care of \_\_\_\_\_ (patient's name) to administer any treatment, therapy or testing that may be deemed necessary or advisable in the diagnosis and treatment of this patient.

**REGARDING PRESCRIPTION REFILLS:** Telephone prescription refills must be requested Monday - Thursday between the hours of 8:30 a.m. and 5:00 p.m.

Telephone prescription refills may be delayed due to the physician's necessity to review your record determining the appropriate medicine to prescribe. Also, please note that it is our belief that narcotic pain relievers are, in general, for short-term use only. These policies are in your best interest and we thank you for understanding.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or other legally responsible person

\_\_\_\_\_  
If other than patient, relationship to patient