Gilbert Neurology — Patient Registration

3507 S. Mercy Rd. #101 Gilbert AZ 85297 1452 N. Higley Rd.Gilbert, AZ 85234 7400 S. Power Rd. #120 Gilbert, AZ 85297
(480) 926-0644 Phone (480) 926-0645 Fax

Patient Name:_____ Gender:___M___F **Date:**_____

Street Address:_____ S.S. #_____

City, State, Zip:_____ **Date of Birth:**_____

Home: (___)_____ Cell: (___)_____

E-mail address:_____

Local Address: _____ ____married ____single ____divorced

City, State, Zip: _____ ____ widowed ____ partnered

Preferred language: ___English ___Spanish ___Other_____ Race: ___American Indian ___ Asian
___African American ___White

Ethnicity: ___Hispanic or Latino ____Not Hispanic or Latino ___Hispanic or Latino ___ Other

Employer:_____ Work Phone: (___)_____

Referring Physician:_____ Phone: (___)_____
Last name First Name

Address:_____ Practice Name:_____

Primary Care Physician:_____ Phone: (___)_____
Last Name First Name

Address:_____ Practice Name:_____

Pharmacy:_____ Phone:(___)_____

Address:_____ City, State, Zip:_____

Mail Order Pharmacy:_____ Phone:(___)_____
Address:_____ City, State,Zip:_____

Primary Insurance:_____ ID #:_____
Address:_____ Group #:_____
City, State, Zip:_____ EffectiveDate:_____

Secondary Insurance:_____ ID #:_____
Address:_____ Group #:_____
City, State, Zip:_____ Effective Date:_____

If the Patient is Not the Primary Insured

Name of Primary Insured:_____ Date of Birth:_____
Relationship to Patient:_____ S.S.#:_____
Employer:_____ Phone: (___)_____

Emergency Contact:_____ Relation to Patient: _____
Address:_____
City, State, Zip:_____ Phone: (___)_____

Do you have a living will? _____yes _____no Do you have a Power of Attorney? ____yes _____no

Signature:_____ Date:_____
Circle one: Patient / Parent / Guardian

Gilbert Neurology

480-926-0644 480-926-0645-fax

Patient Communication and Consent

Patient Name: _____Date of Birth: _____

There are occasions when Gilbert Neurology may have to call to discuss Confidential Protected Health Information. Please let us know how you would like us to get this information to you:

____ Ok to call my home/cell phone and leave a message on the answering machine

____ Ok to call my home but DO NOT leave a message

____ Do Not call my home phone but call this number ( ) _____

____ Do Not leave message with family member

Who may receive information regarding your Protected Health Information?
Check all that apply.

____ Spouse Name and date of birth: _____

____ Children Name and date of birth _____

Name and date of birth _____

Name and date of birth _____

____ Parents Names and date of birth: _____

____ Significant Other/Friend Name and date of birth: _____

_____

I have received a copy of the Notice of Privacy Practices from this provider and authorize the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to Gilbert Neurology.

I hereby authorize Gilbert Neurology to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care.

I also authorize the release of information that may be necessary in the processing of any insurance claims.

I also authorize the release of any medical records including pharmacy records to Gilbert Neurology upon request.

Signature: _____Date: _____

Gilbert Neurology, P.L.L.C. Financial Policy

3507 S Mercy Rd., Suite 101 Gilbert, AZ 85297 (480) 926-0644 Fax (480) 926-0645
1452 N. Higley Rd. Gilbert, AZ 85234 (480) 926-0644 Fax (480 926-0645

Patient Name_____

*****PLEASE INITIAL ALL OF THE FOLLOWING*****

_____ **Unless 24-hour notice is given, I understand that there will be a $25 charge for broken appointments and a $50 charge for procedures and infusions.**

_____I understand that I am financially responsible for any copayments, deductibles, coinsurance and all charges which are not covered by my insurance. I understand that verification of coverage does not guarantee payment of benefits. My insurance company determines insurance benefit payments. I understand I will be responsible for that portion of all charges not covered by my insurance.

____I understand that I am responsible for all charges if it is determined that the insurance information I have provided is not correct.

____**Due to the large number of insurance plans and policies, it is the patient's responsibility to be aware of the services that are covered by your plan. Please call your insurance company for an explanation of your benefits.**

____**I understand that I am responsible for my co-pay at the time of my visit. We accept cash, all major credit cards, and personal checks.**

____I understand that there is a $25 charge for a Non-Sufficient Funds (NSF) check.

____I understand that there is a charge ranging from $25-$300 for all forms deemed necessary and filled out by the Physician OR Nurse Practitioner (e.g. Disability, FMLA, etc.) and I understand that I if I need an appointment with the Doctor or Nurse Practitioner to fill out these forms we will not be billing the insurance. The form fee must be paid at time of service or upon completion of the forms.

____I understand that Gilbert Neurology does not accept liens; worker's compensation, or MVA/auto claims and that I am responsible for any insurance claims denied as such. If my medical insurance denies or takes back any monies provided, I understand that I am responsible to pay all claims in full.

____If my account is not paid in full within 90 days, I understand that it will be considered delinquent. No additional appointments will be made for patients with delinquent accounts until they are brought current. Delinquent accounts will be turned over to a collection agency.

____I hereby authorize the release of information that may be necessary in the processing of any insurance claims.

____I hereby authorize my insurance company to make payment directly to: Gilbert Neurology, P.L.L.C.

____**I have read and I understand the above Financial Policy and I agree to abide by its terms. No changes to this policy by the patient will be acknowledged. Questions may be directed to the billing office.**

Signature of patient (or parent / guardian) _____

Print Name _____ **Date**_____