

# Gilbert Neurology

# Patient Registration

3507 S. Mercy Rd. Ste 101 Gilbert AZ 85297

7400 S Power Rd. Ste 120 Gilbert AZ 85297

Phone (480) 926-0644

Fax(480) 926-0645

Patient Name: \_\_\_\_\_ Gender    M    F Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ S.S. # \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

E-mail address: \_\_\_\_\_

Physical Address (if different from mailing): \_\_\_\_\_    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

Referring Physician: \_\_\_\_\_  
(First and Last Name)

Phone: (\_\_\_\_) \_\_\_\_\_ Practice Name: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_  
(First and Last Name)

Phone: (\_\_\_\_) \_\_\_\_\_ Practice Name: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_

Cross streets \_\_\_\_\_

Mail Order Pharmacy: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
(PLEASE STILL PROVIDE PHYSICAL COPY OF INSURANCE CARD)

Secondary Insurance: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
(PLEASE STILL PROVIDE PHYSICAL COPY OF INSURANCE CARD)

Name of Primary Insured (if not self): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ S.S.#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Do you have a Living Will?    yes    no Do you have a Health Care Power of Attorney?    yes    no  
\*If yes, please provide a copy for our office\*

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

7400 S. Power Rd. Suite 120 Gilbert, AZ 85297

Phone: (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 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 \_\_\_\_\_