NEW PATIENT INFORMATION FORM

Patient Name:_____ **Date Of Birth:**_____ **Sex: M or F**

Address:_____ **Apt#**_____ **City:**_____

State:_____ **Zip:**_____ **Home Phone:**_____ **Work**_____

Referring Physician/PCP_____ **Phone** _____

Employer:_____ **Address**_____

SS#:_____ **Employer Phone**_____ **Spouse Name:**_____

Emergency Contact (other than spouse)_____ **Phone**_____

E-Mail Address: _____

Worker's Compensation Insurance Company _____

Claims address:_____

Date of Injury _____ **Claim#**_____

Adjuster's Name _____ **Phone#**_____

Employer when injured: _____

Employer Contact Name:_____**Phone#**_____

IT IS YOUR RESPONSIBILITY to read and understand your own insurance policy. Certain services and procedures may/may not be covered depending on your individual insurance policy, or may require referrals/authorizations. **IT IS YOUR RESPONSIBILITY** to contact your insurance company to find out whether referrals/authorizations are needed and to facilitate the receipt of them if required. **IT IS YOUR RESPONSIBILITY** to know whether we are participating physicians with your plan or whether the services you are coming for are covered at our office. It is important for you to recognize that insurance companies differentiate plans by PPO, HMO, POS, EPO, Indemnity, etc. thus you will need to know which plan you are on to obtain proper verification of whether the physician you are seeing in our office is participating.

IT IS YOUR RESPONSIBILITY to provide **GEORGIA NEUROLOGY AND SLEEP MEDICINE** with correct and updated insurance information prior your office visit. If you fail to do so, **YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL** in the event that insurance denies payment due to:

- Insurance coverage does not provide benefits because we are not participating physicians in your plan
- Insurance coverage is not effective on the date of your visit or we weren't notified of proper information
- A procedure is not paid due to your lack of response to requested information from us or your carrier
- A non-covered service is performed or a service is denied due a patient's negligence in providing information regarding insurance plan coverage or changes.
- Insurance authorizations or referrals are not obtained at all or timely

I have read and understand the office policy stated above and agree to accept the responsibility as described above. In the event that my account is turned over to a collection agency due to non-payment of a patient responsible balance, I agree to pay any additional fees charged by the collection agency for collection of the balance due. I further authorize the release of pertinent information to any requesting insurance carrier, SSI, HCFA, or other party involved in payment or settlement of my claims. I further authorize release of pertinent information to/from any medical facility/physician involved in my correlated treatment with this office. A copy of this agreement may be used in place of the original and should be considered effective from the signed date. **I understand that refusal to sign this agreement is grounds for refusal of treatment.**

Patient/Guardian Signature:_____ Date:_____