MICHIGAN NEUROLOGY, P.L.L.C.
1030 Harrington Blvd., Suite 205
Mt. Clemens, MI 48043
Ph: (586) 493-3188 Fax: (586) 493-3191

Date:

LAST NAME, FIRST NAME, MIDDLE INITIAL:			
ADDRESS:		MAIN PHONE:	
CITY, STATE, ZIP:		ALTERNATE PHONE:	
EMAIL:		GENDER AT BIRTH: ☐ MALE ☐ FEMALE	
		PREFERED PRONOUNS:	
DATE OF BIRTH:	AGE:	SOC SEC NUMBER:	
MARITAL STATUS: Year Married _________ Year Divorced ________ Year Widowed ________ Single __________ (never married)			
PHARMACY:	ADDRESS OR CROSS STREETS:		PHONE:
MAIL ORDER PHARMACY:		PHONE:	
REFERRING DR:	PHONE:		FAX:
PRIMARY CARE DR:	PHONE:		FAX:

IS THIS VISIT RELATED TO:	☐ WORK INJURY	☐ AUTO ACCIDENT	☐ N/A

PRIMARY INSURANCE:		CONTRACT #:
SUBSCRIBER:	DOB:	GROUP #:
RELATIONSHIP:		EMPLOYER:
SECONDARY INSURANCE:		CONTRACT #:
SUBSCRIBER:	DOB:	GROUP #:
RELATIONSHIP:		EMPLOYER:
RX COVERAGE:		ID#:
RXBIN:	RXPCN:	RXGRP:

I have reviewed the above information and verify that it is correct.

Signature: ____ Date: ___________________
Signature: ____ Date: ____________________
Signature: ____ Date: ____________________
Signature: ____ Date: ____________________

MICHIGAN NEUROLOGY, P.L.L.C.

Date:

RELEASE OF INFORMATION

Patient Name: ____ Birthdate: ______________________

I give Michigan Neurology, P.L.L.C. permission to speak with:

Name:____________________________ Relationship:__________________ Phone:___________________

Name:____________________________ Relationship:__________________ Phone:___________________

Name:____________________________ Relationship:__________________ Phone:___________________

☐ I do not want information released to anyone at this time

Please answer the following questions regarding voice mail use:

When calls are made to you regarding confirming appointments, may appointment times and test instructions be left on your home answering machine? Yes ☐ No ☐ Cell phone voice mail? Yes ☐ No ☐

When awaiting lab or test results, may we leave detailed results on your home answering machine? Yes ☐ No ☐ Cell phone voice mail? Yes ☐ No ☐

EMERGENCY CONTACT INFORMATION

Person to be contacted in case of emergency: ____

Phone Number(s): ____________________________________ Relationship: ____________________________

ACKNOWLEDGMENT OF BENEFITS/HIPPA/FINANCIAL RESPONSIBILITY

I, the undersigned, realize that all medical and surgical charges incurred are my responsibility and payable by me regardless of what my insurance pays. I hereby authorize and direct my insurance carrier(s), including Medicare (assigned charges), to pay directly to Michigan Neurology P.L.L.C. any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan, including deductibles and co-payments.
I have read and signed the practice's Notice of Privacy Practices for Protected Health Information and understand this authorizes my physician to release to my insurance company the medical information necessary to process my claims. This authorization is valid until termination of enrollment in the health plan.

____
Signature (Patient or authorized representative) Date

Signature: ____ Date: ______________________

Signature: ____ Date: ______________________

Signature: ____ Date: ______________________

Signature: ____ Date: ______________________

MICHIGAN NEUROLOGY, P.L.L.C
Assignment of Insurance Benefits

Today's date_______________________

PATIENT INFORMATION (please print)

Name____ DOB__________________________

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature of this document authorizes my physician or it's entities to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, ____, hereby authorize _______________________________
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to Michigan Neurology, P.L.L.C. all benefits, if any, otherwise payable to me for his/her services. I understand I am financially responsible for all charges incured. I further acknowledge that any insurance benefits, when received by and paid to Michigan Neurology, P.L.L.C. will be credited to my account, in accordance with the above said assignment. This authorization is valid until termination of enrollment in the health plan.

____ ______________________________
(Authorized Signature of Subscriber) (Date)

Signature: ____ Date: ____________________

Signature: ____ Date: ____________________

Signature: ____ Date: ____________________

Signature: ____ Date: ____________________