INSURANCE AUTHORIZATION

Appointment Date: _____

Doctor: _____

NorthEast Neurology

704-403-1911 • TOLL FREE 800-230-1720 • FAX 704-403-1901
315 Medical Park Drive • Suite 202 • Concord, NC 28025
16623 BirkdaleCommons Parkway • Suite 110 • Huntersville, NC 28078
1585 Forney Creek Parkway • Suite 2200 • Denver, NC 28037

First Name: _____ Last Name: _____

Date of Birth: _____ Sex: ☐M ☐F Social Security #: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Are you employed full time: ☐Yes ☐No Employer: _____

Address: _____ Phone #: _____

Married: ☐Yes ☐No : Next of Kin: _____ Relationship: _____

Home #: _____ Cell #: _____ Work #: _____

Emergency Contact: Nearest relative or friend **NOT LIVING WITH YOU**

Name: _____ Relationship: _____

Home #: _____ Cell #: _____ Work #: _____

Primary Care Physician: _____ Referring Physician: _____

In the past, have you ever been seen by a neurologist? ☐No ☐Yes

If so: When: _____ Name: _____ Location: _____

INSURANCE POLICY: You must bring a current copy of your insurance card(s).

INSURANCE AUTHORIZATION AND ASSIGNMENT

FOR MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to NorthEast Neurology for any services furnished me by the physician / supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

FOR MANAGED CARE PATIENTS

I authorize NorthEast Neurology to release any information (including copies of my medical records) acquired in the course of my examination or treatment to my Primary Care Physician.

FOR ALL PATIENTS

I authorize NorthEast Neurology to release any information (including copies of my medical records) acquired in the course of my examination or treatment to any insurance companies when making a claim on my behalf. I further authorize payment of these medical benefits to NorthEast Neurology for these services, if applicable. I understand this authorization allows the release of all information in my file including information reguarding any chemical dependency problem and/or treatment.

I will be responsible for paying this coinsurance amount at the time of service.

I photocopy of this document shall be considered as valid as the original.

Date _____ Signature _____