MARYLAND NEUROLOGICAL CENTER, LLC

Please assist us by verifying this information is correct and complete

Last revised 2/26/14

Patient Name	Birthdate	Account #	E-Mail
Pt. Address **PLEASE CHECK CITY/STATE/ZIP**		Work Phone	Home Phone
Emergency Contact Name	Emergency Contact Phone Number **(note whether home, work, or cell)**		Patient Cell Phone
Guarantor Name	Guarantor Address	Guarantor Phone	
Primary Care Physician	Primary Care Physician Phone Number	Preferred Language	
Referring Physician	Referring Physician Phone Number	Race	Ethnicity
Primary Insurance Name	Name of Insured	Certificate Number	
	Primary Insured Date of Birth	Group Number	
Secondary Insurance Name	Name of Insured	Certificate Number	
	Secondary Insured Date of Birth	Group Number	

Option: OPT OUT – No Referral _____

Authorization To Pay Benefits To Physician: I authorize Maryland Neurological Center, LLC to release to my insurance company any information regarding my treatment and diagnosis of my condition that they may consider appropriate to obtain payment for services rendered to me. I also authorize and request such payment to be made directly to this physician for any amounts due for medical and surgical services. I understand that I am financially responsible for any balance not covered by my insurance or any non-covered benefits, including injections or other laboratory tests necessary to diagnose or treat my condition.

If I am also a Medicare patient, I request payment of authorized Medicare benefits be made on my behalf to Maryland Neurological Center LLC, PC for any services furnished to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents needed to determine these benefits payable for related services.

Acknowledgement of Receipt of Notice of Privacy Practices: The undersigned patient or legally authorized representative of the patient acknowledges that he or she personally received a copy of the Maryland Neurological Center, LLC Notice of Privacy Practices on the date indicated below.

_____ _____

Signed (patient or parent if minor) Date