TRI-CITY NEUROLOGY, LLC

200 EAST BATTLE STREET • TALLADEGA, AL 35160
(256) 362-9677

PATIENT INFORMATION

Patient Name: Last _____ First _____ Middle _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Cell Phone: _____

Sex: _____ Race: _____ Marital Status: _____ Birthdate: _____

Retired: _____ Employed: _____ Full time student: _____ Part time student: _____

Employer: _____ Phone: _____

Social Security: [Can provide in person during visit] _____ Drivers License: _____

Person responsible for account: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Employer: _____ Phone: _____

Social Security: _____ Drivers License: _____

Spouse's Name: _____ Employer: _____ Phone: _____

Person to notify in case of emergency: _____ (Outside Your Home) Phone: _____ (Other Than Your Number)

Relatives or friends that are patients: _____

Drug Allergies: _____

Major Medical Problems:: _____

Have you arranged for a Living Will? (Advanced Directives) ☐ Yes ☐ No Have you appointed a durable power of attorney? ☐ Yes ☐ No

INSURANCE POLICY INFORMATION

Insurance Company (Primary): _____

Policy holder's name: _____ Birthdate: _____ / _____ / _____

Employer: _____

Contract or group: _____

Relationship of patient to policy holder: _____

Insurance Company (Secondary): _____

Policy holder's name: _____ Birthdate: _____ / _____ / _____

Employer: _____

Contract or group: _____

Relationship of patient to policy holder:

Referred by: _____

CONSENT FOR TREATMENT: - I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician, his nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION - I authorize TRI-CITY NEUROLOGY LLC to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to TRI-CITY NEUROLOGY LLC of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the TRI-CITY NEUROLOGY LLC charges for these services. I understand that I am financially responsible to TRI-CITY NEUROLOGY LLC for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT - For services furnished by TRI-CITY NEUROLOGY LLC I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee.

SIGNATURE: _____ DATE: _____

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