Premier Neurology & Wellness Center
1050 SE MONTEREY RD., SUITE 201
STUART, FL 34994
PHONE: 772-210-2447
FAX: 772-261-4028

Patient Demographics Information

Patient's Name _____
First Middle Last

Patient's Address: _____

City: _____ State: _____ Zip: _____

Phone numbers: Home: _____ Work: _____ Cell: _____

DOB: _____ Age: _____ Sex: _____ SSN: _____

Marital Status: _____ Email: _____

Primary Physician: _____ Ph#: _____

Referring Physician: _____ Ph #: _____

Pharmacy: _____

In case of emergency, whom should be notified? _____

Relationship to patient: _____ Tel #: Home _____

Medications	Dose	How Often
1.		
2.		
3.		
4.		
5.		
6.		

Patient Contact Authorization / HIPPA

Please list the names of any individuals whom you authorize us to speak with and/or leave messages with relating to your medical care. (We will not leave messages containing to sensitive health related information.)

1.) _____

2.) _____

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Authorization to Obtain/Disclose Medical Records

I:_____ D.O.B.:_____, authorize Premier Neurology and Wellness Center to obtain and/or disclose my medical records.

Physician or individual:

_____

Address:

_____

_____

Phone: _____ **Fax:** _____

- ☐ **Imaging**
- ☐ **Labs**
- ☐ **All Records**

Signature of Patient or Legal Guardian: _____ **Date:** _____

Printed Name of Patient or Legal Guardian: _____ **Date:** _____

Important:

This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal health insurance portability & accountability act (HIPPA) privacy rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt form disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any discloser, dissemination, distribution or coping of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.

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PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Premier Neurology & Wellness Center to serve the health care needs for you. We are pleased to participate in your health care and look forward to establishing a lasting relationship as your health care provider. As part of this relationship, we have outlined our expectations for your financial responsibility in our Patient Financial Responsibility Policy. Please read this document thoroughly.

Address Change

- It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information. We sometimes mail out important information in addition to billing statements.

Co-payments, Deductibles and Co-Insurance

- Co-payments are collected at the time of check-in.
- Insurance deductibles and fees for services not covered by your insurance policy, therefore if you are responsible for these, they are due at the time the service is rendered. We accept cash, check, care credit and most major credit cards.

Billing

- If you owe additional money after your visit, you can expect to receive a statement. Statements are mailed out monthly. Payment is expected within 15 days of receipt of your statement.

Failure to Pay

- Patients who ignore collection notices and fail to pay their balance risk negative credit ratings and possible dismissal from the practice.
- Past Due accounts may hinder your ability to have appointments scheduled.

Fees

- Returned checks are subject to a $25 fee.
- Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment may result in a charge of $50.00. Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a fee for canceled or missed appointments. If you must cancel an appointment, Premier Neurology & Wellness Center requires a minimum of 24 hours' notice.
- There is an administrative fee for completing forms such as DMV, physical forms, FMLA, leave of absence, disability etc. Most forms require 5 to 7 working days to research your information and complete the form. This fee is varies from $20.00-$50.00 depending on which form it is.
- There may be additional charges applied to your account if we are asked to copy medical records per patient request or participate in a Deposition or Phone Consultation on your behalf. Our fee is $1.00 per page.

Guarantor

- Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. If another party is responsible for payment of your account, you must pay your balance in full and negotiate repayment with them outside of our office. This policy includes individuals negotiating divorce agreements.

Insurance

- **It is important for you to be an informed consumer, who understands the specifications of your insurance policy.** Your health insurance policy is a contract between you and your Health Insurance Company or employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether or not our physicians participate.

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- As a courtesy to you, we will bill your insurance company directly for medical services rendered. If problems arise regarding coverage issues, we will attempt to work with your insurance company to help resolve them prior to making it your responsibility. However, please be advised that you are nevertheless ultimately financially responsible for payment of medical services rendered.
- If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicare consider some services to be "non-covered," in which case you are responsible for payment in full.
- If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket fees and coverage limits.
- Premier Neurology & Wellness Center contracts with many insurance plans. Before your appointment, please be sure your doctor is in-network and the services are covered under your plan. If your doctor is out of-network, you will be billed for the cost of care.

Non-Emergency Appointments

- Outstanding balances or failure to pay co-payments upon check-in may result in physicals and other routine or screening appointments being rescheduled.

Referrals and Authorizations

- Please be aware of and provide any required referrals or authorizations in advance of the appointment of service. If you do not provide these before care is provided, you will be responsible for the cost of the care. When in doubt contact your plan directly for clarification.

Self-Pay Patients

- Self-pay patients should be prepared to pay the full and entire amount at the time of each visit.

Worker's Compensation

- The patient must provide at time of service: a claim number, name of the carrier, the date of injury, employer at time of injury and name and number of the claim adjuster. Without this information, the patient will be held responsible for all charges, and payment will be collected at time of service.

Motor Vehicle Insurance (PIP)

- The patient requests that claims be submitted to their motor vehicle insurance carrier. Patient understands they will be responsible for bills incurred by them in the event that PIP benefits has been exhausted or denied.

Consent for Treatment

- I give consent to Premier Neurology & Wellness Center, its staff, physicians and other practitioners (the "Practice") to provide and perform such medical care, tests, procedures, and other services that are deemed necessary or beneficial by the Practice for my health and well-being.

_____ _____

Printed name of Patient **Date of Birth**

_____ _____

Signature of Patient or Legal Guardian **Today's Date**