



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: _____
Last First Middle Initial

DOB: _____ Sex: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Ph#: _____ Work: _____ Cell: _____

Marital Status: _____ Email: _____

Primary Physician: _____

Ph#: _____

Referring Physician: _____

Ph#: _____

In case of emergency, whom should be notified? _____

Relationship to Patient: _____ Ph#: _____

Pharmacy: _____ Zip: _____ Ph# _____



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 pertaining to sensitive health related information.)

1. _____ Ph # : _____

2. _____ Ph # : _____

PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Premier Neurology & Wellness Center to serve the health care needs for you. We are please 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, & 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 business days to research your information and complete the forms. This fee varies from \$20.00-\$50.00 depending on which form it is.
- There may be additional charged 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 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 our physicians participate or not.
- 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 your payment of medical services rendered.

Premier Neurology & Wellness Center



- 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 contacts 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 the injury, employer at the time of injury, and name and number of the claim adjuster. Without this information the patient will be held responsible for all changes, 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. Patients understands they will be responsible for bills incurred in the event that PIP benefits have been exhausted or denied.

Consent for Treatment

- I give consent to Premier Neurology & Wellness Center, its staff, physicians, and other practitioners 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/Legal Guardian

Today’s Date

Authorization to Disclose Protected Health Information

Premier Neurology & Wellness Center



I _____ D.O.B _____,
authorize Premier Neurology & Wellness Center to OBTAIN/RELEASE my protected medical records.

Physician or individual:

Address:

Phone: _____ Fax: _____

- Imaging
- Labs
- All Records

Signature of Patient/Legal Guardian: _____ Date: _____

Printed Name of Patient/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 who it is addressed and may contain information that is proprietary, confidential, and/or exempt from disclosure under applicable law. If you are not the intended recipient (or any employee or agent responsible for delivering this facsimile transmission to the intended recipient), you hereby notify that any discloser, dissemination, distribution, or coping of this information is strictly prohibited and me 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.

Date: _____

Patient Name: _____ Date of Birth: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND WHO PRESCRIBES THEM.
(OR TAPE CURRENT LIST TO THIS LIST)



IF YOU DO NOT TAKE ANY MEDICATIONS, VITAMINS, HERBAL REMEDIES OR OVER THE COUNTER DRUGS, PLEASE STATE THAT.

LIST OF CURRENT MEDICATIONS

MEDICATION NAME & STRENGTH	DOSAGE	PHYSICIAN AND PHONE #
VITAMINS/HERBAL REMEDIES/OVER THE COUNTER DRUGS		