PATIENT INFORMATION

unity health network
Neurology & Neuroscience

Primary Care Physician: _____

Patient Name: _____

Patient Address: _____

City, State, Zip: _____

Phone: _____

Marital Status: _____ Date of Birth: _____

Sex: _____ SSN: _____

Race (circle one): Asian Native Hawaiian African American White Hispanic Other Refused

Ethnicity (circle one): Hispanic Non-Hispanic Refused

Email Address: _____

Primary Pharmacy Name: _____ Phone Number: _____

Patient Employer: _____

Employer Address: _____

City, State, Zip: _____

Primary Insurance: _____

Group #: _____ ID #: _____

Policy Holder Name: _____

Subscriber Date of Birth: _____

Secondary Insurance: _____

Group #: _____ ID #: _____

Guarantor Name: _____

Guarantor Address: _____

City, State, Zip: _____

All professional services rendered are charged to the patient. Necessary forms must be completed to expedite insurance carrier payments. If you are covered by a plan with a restrictive network, it is your responsibility as the insured patient to seek professional care with a participating provider within your plan. The patient (or guardian) is responsible for all fees, regardless of insurance coverage.

I hereby give the physicians of Neurology & Neuroscience Associates, Inc. permission to treat me or my dependent(s), and I authorize NNA to furnish any medical information necessary for insurance claim submission and/or payment. I understand that I am responsible for any remaining fees not covered by insurance.

I further understand that some or all of the services rendered may be deemed "not covered" by my insurance carrier and that I will be billed for such services.

I authorize payment of medical benefits to the physicians of NNA for the services described herein. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees and services rendered.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____