COLORADO INSTITUTE FOR NEUROMUSCULAR AND NEUROLOGICAL DISORDERS PATIENT INFORMATION FORM

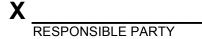
TODAY'S DATE		
PATIENT'S NAME AND ADD	RESS	
LAST	FIRST	M.I
ADDRESS	СІТҮ	STATEZIP
HOME PHONE	CELL	_ PREFERRED # HOME / CELL
DATE OF BIRTH	AGE SEX	
SOCIAL SECURITY #	MARITAL STATUS	
(NAME)	(STREET ADDRE	SS) (CITY/ST/ZIP)
	WORK PHONE	E
MAY WE CONTACT YOU AT WO	ORK (CIRCLE ONE)? Y N	
PARENT/GUARDIAN/SPOUS	E	
LAST	FIRST	M.I
ADDRESS	CITY	STATE ZIP
HOME PHONE	CELL	
DATE OF BIRTH	AGE SEX	
SOCIAL SECURITY #	MARITAL STATUS	
RELATIONSHIP TO PATIENT		

PRIMARY MEDICAL INSURANCE

(Primary Insurance Company Name)	(ID #)	(Group #)	
(Address)	(City/State/Zip) (Phone)		(Phone)
(Policy Holder Name)	(ID#)	(INSURI	ED Date of Birth)
SECONDARY MEDICAL INSURANCE			
(Primary Insurance Company Name)	(ID #)	(Group #)	
(Address)	(City/State/Zip) (Phone)		
(Policy Holder Name)	(ID#)	(POLICY HOLDER Date of Birth)	
EMERGENCY CONTACT INFORMATION			
(Name)	(Phone)		(Relationship)
(Address)	(C	ity) (State	e) (Zip)

AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, herby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient when that treatment is not considered to be a covered service by the primary insurer and/or a third party insurer or other payor.



DATE

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, the undersigned responsible party, hereby authorize this office/its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be, liable for all or part of the provider charges.

I authorize the release and disclosure of any and all of my or my child's medical records to any other entity, including but not limited to specialty physicians, hospitals or other health care providers, which may be of assistance, in the opinion of this office, in providing treatment to the patient. I authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I authorize this office and/or its employees to release, via fax machine, medical records which are needed in order to provide the patient with the most appropriate medical care.

I authorize and request that payment of any third party or insurance company benefits be made directly to this office for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

RESPONSIBLE PARTY	DATE		
RESPONSIBLE FART	DATE		
NOTI	CE OF PRIVACY PRACTICES		
, the undersigned, have received a copy of and Neuromuscular and Neurological Disorders.	understand the Privacy Practices of the Colorado Institute for		
X			
RESPONSIBLE PARTY	DATE		
Colorado Institute for Neuromuscular and Neuro	ological Disorders may also disclose my health care information to:		
NAME:	RELATIONSHIP		
	toto and includes only personal healt for Neuromuscular and Neurological Disorders and its providers		
V			

Patients with Health Plans, please present your insurance ID Card to the receptionist after completing this form.
Some contract Health Plans (HMO, PPO, IPA, etc) require a co-payment at the time of service. Please have this ready.

RESPONSIBLE PARTY

DATE