COLORADO INSTITUTE FOR NEUROMUSCULAR AND NEUROLOGICAL DISORDERS
PATIENT INFORMATION FORM

TODAY'S DATE _____

PATIENT'S NAME AND ADDRESS

LAST _____ FIRST _____ M.I. _____

ADDRESS _____ CITY _____ STATE ___ ZIP_____

HOME PHONE _____ CELL _____ PREFERRED # HOME / CELL

DATE OF BIRTH _____ AGE_____ SEX _____

SOCIAL SECURITY # _____ MARITAL STATUS _____

EMPLOYER

_____

(NAME) (STREET ADDRESS) (CITY/ST/ZIP)

OCCUPATION _____ WORK PHONE _____

MAY WE CONTACT YOU AT WORK (CIRCLE ONE)? Y N

PARENT/GUARDIAN/SPOUSE

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)

(Policy Holder Name) (ID#) (INSURED 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) (City) (State) (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.

X _____

RESPONSIBLE PARTY 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.

X _____

RESPONSIBLE PARTY DATE

NOTICE OF PRIVACY PRACTICES

I, the undersigned, have received a copy of and understand the Privacy Practices of the Colorado Institute for Neuromuscular and Neurological Disorders.

X _____

RESPONSIBLE PARTY DATE

Colorado Institute for Neuromuscular and Neurological Disorders may also disclose my health care information to:

NAME:_____**RELATIONSHIP** _____

This authorization is effective from _____ to _____ and includes only personal health information pertaining to Colorado Institute for Neuromuscular and Neurological Disorders and its providers.

X _____

RESPONSIBLE PARTY DATE

☑ 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.