NEUROCARE CENTER

NEUROCARE CENTER, LLC

3290 N. Ridge Rd. Suite 240 Ellicott City, MD 21043
Tel: 410-730-6911 Fax: 410-730-1599

Patient Registration

_____ First Visit _____ Existing Patient

~Confidential~

Patient Information (Please PRINT IN BLACK INK) Existing patients: Please revise all information that has changed since your last visit.

Date of Visit _____ ☐ Consultation with Dr. Babkes ☐ Consultation with Dr. Reaven ☐ EMG ☐ EEG ☐ Other test

Is today's visit due to an auto accident? ☐ Yes ☐ No Is today's visit a Workers' Comp Case? Yes ☐ No ☐

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Last Name _____ M.I. _____ First Name _____

Sex: ☐ Male ☐ Female Birth Date _____ Age _____ Email _____

Street Address _____ City _____ State _____ Zip Code _____

Best number to reach you (___)_____ Home Phone (___)_____ Cell (___)_____ Work (___)_____

Primary Care Physician: Name _____ Tel. _____ Fax: _____ Referred by _____

Student: ☐ Full time ☐ Part Time / ☐ Married ☐ Divorced ☐ Legally Separated ☐ Single

In case of emergency, whom may we contact? _____ Phone (___)_____ Relationship _____

Patient Employed By _____ Occupation: _____ Business Address: _____

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Other ☐ Parent (if patient is a minor) _____
(If **self**, please skip to next section)

Name of person responsible _____ Relation to you _____ Birth Date _____ Telephone (___)_____

Street Address _____ City _____ State _____ Zip Code _____

Person Responsible Employed By _____ Occupation: _____ Business Address: _____

Insurance Information

Do you have Medical Insurance? ☐ Yes ☐ No (or) ☐ Self-Pay? (or) Other:

Does your insurance company require a referral from your primary care physician to see a specialist? ☐ Yes ☐ No If yes, please request referral from your primary care provider well ahead of your visit.

Please provide your insurance information in the boxes below: **Required by HIPAA*

Primary Medical Insurance Company	Secondary Medical Insurance Company
Name of Primary Insurance _____	Name of Secondary Insurance _____
ID/Policy Number: _____	ID/Policy Number: _____
Group Number: _____ Group Name: _____	Group Number: _____ Group Name: _____
*Subscriber's Name: _____ *(Person who is Policy Holder)*	*Subscriber's Name: _____ *(Person who is Policy Holder)*
*Subscriber's Birth Date _____	*Subscriber's Birth Date _____

Optional *(Requested by the government):* Race: _____ Ethnicity: ___ Latino ___ Non-Latino Preferred Language: _____

CONSENT FOR INFORMATION USE AND DISCLOSURE, AND INSURANCE ASSIGNMENT (Please read and sign) By signing you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in trust on your prior consent. I hereby authorize NeuroCare Center, LLC to provide health information requested by my insurance co. and/or other healthcare providers involved in my care. I agree to provide NeuroCare Center, LLC with my health insurance information and to provide updates if my insurance changes, so that NeuroCare Center may (as a service) submit claims for payment to my insurance company, on my behalf. I assign all such payments to NeuroCare Center, LLC for services rendered to me (or to my dependents). Many insurance carriers require that patients pay a portion of fees for their healthcare (in the form of copays or co-insurance); I agree to pay in full all such amounts designated as "patient responsibility" by my insurance carrier. If my insurance carrier declines to pay for my treatment, I will pay for all services rendered to the above named patient. I agree to pay any outstanding balances within 30 days or to request a payment plan, if full payment is not possible. I agree to pay any copay ***prior to receiving service*** *(in accordance with my insurance company's requirements)*.

Not covered by health insurance: $30 "no show" fee for failure to cancel a scheduled appointment with at least 24 hours notice. I agree to self-pay this charge.

Signature: _____ Date: _____

Name (please print): _____