

PATIENT'S EMPLOYMENT

Employed: Full-time Part-time Not Retired Employer _____

Student: Full-time Part-time School _____

Work Address _____ City _____ State _____ Zip _____

Work Phone () _____ Occupation/Position _____ Length of Employment _____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT)

Name _____ Telephone () _____

Social Security Number _____ Date of Birth _____

Relationship to Patient _____ Address _____ Cell Phone () _____

Employer _____ Occupation/Position _____ Length of Employment _____

Work Address _____ Work Phone () _____

ALTERNATE CONTACT PERSON

A local friend or relative who does not live with you and can reach you in case of emergency.

Name _____ Relationship to Patient _____

Address _____ Telephone () _____

IN ORDER FOR OUR PHYSICIANS AND STAFF TO PROPERLY SERVE YOUR HEALTH CARE NEEDS, AND TO AVOID MISUNDERSTANDINGS REGARDING OUR PAYMENT POLICIES, PLEASE REVIEW THE FOLLOWING:

1. You are responsible for your bill. For patients without insurance, payment in full is due at the time service is rendered unless prior arrangements have been made with our Business Office.
2. Patients with insurance are responsible for any visit co-payment, percentage and/or deductible amount not yet met at the time service is rendered. As a courtesy to you, we will submit an insurance claim to your primary and secondary insurance. Any amount not covered by insurance must be paid by you.
3. MasterCard, Visa, Discover or Visa/Mastercard debit are accepted for your convenience.
4. A service charge equal to 1-1/2% per month will be applied to all account balances after 90 days.
5. Failure to make prompt and timely payments may result in a denial of future credit or service.
6. We do accept Medicare assignment. As an additional courtesy to our Medicare patients with supplemental insurance coverage, we will submit a claim form to this secondary carrier for you.

I have read and understand the payment terms listed above. I authorize Medford Neurological Clinic, Inc. to release to my insurance company such medical information as they may request. I hereby assign to Medford Neurological Clinic, Inc. all insurance benefits for services provided by them. A photocopy of this assignment is to be considered as valid as an original.

Signature of patient (Parent/Guardian if patient is a minor) _____ Date _____

Reviewed with patient _____ Date _____