220 EXECUTIVE CENTER PARKWAY
FREDERICKSBURG, VA 22401
(540) 899-2900 • FAX (540) 372-6928

NEUROLOGY ASSOCIATES of Fredericksburg

REGISTRATION INFORMATION

Home phone_____ Cell phone _____Date _____

Patient_____
Last Name First Name Initial

Responsible Party (if a minor) _____

Street Address_____

City _____ State _____ Zip Code _____

Male ____ Female ____ Age ___ Birthdate _____ Single _____ Married _____ Widowed _____ Divorced _____

Patient SSN _____ Responsible Party SSN _____

Patient Employer _____ Business phone_____

Spouse/Responsible Party Name _____Birthdate _____

Spouse/Responsible Party Employer _____ Business phone_____

Primary Insurance Co._____ ID # _____ Group # _____

Secondary Insurance Co._____ ID # _____ Group # _____

Emergency Contact _____Phone # _____ Relationship to Patient _____

Referring Physician _____ Phone number _____

Please circle if injury is related to Employment: YES / NO ; an Auto Accident: YES / NO ; or Other Accident YES / NO; Date of Accident _____/_____/_____ ; State accident occurred in? _____.

ASSIGNMENT AND RELEASE

I, the undersigned have insurance coverage with _____ and assign directly to Neurology Associates of Fredericksburg all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefit be made either to me or on my behalf to Neurology Associates of Fredericksburg for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of Medicare.

_____ _____
Beneficiary Signature Date