Coastal Neurological Medical Group, Inc.

Dee E. Silver, M.D.

We're here to help!

******Please Print******

_____
Account number

Name_____
Last First M

Address_____ Apt #_____

City_____ State_____ Zip Code_____

Home Phone ( )_____ Work Phone ( )_____ Cell Phone ( )_____

Date of Birth _____ Male_____ Female_____ SS#_____

Primary Care Physician_____ Phone ( ) _____

Referring Physician_____Phone ( ) _____

Insurance Carrier _____ Second Insurance _____

In Case Of Emergency Contact:

Name_____ Relation_____ Phone ( ) _____

Financial Policy

It is the policy of our practice to collect all co pays, co-insurance and deductibles at the time of service. We verify eligibility and benefits with every insurance carrier prior to the patient being seen. If the insurance company states that you are ineligible for coverage, payment is required in full at the time of service. We determine the amount to collect based on the benefits provided by your insurance company. If you are on a PPO plan, the amount we will collect are based on the contracted rates provided by your insurance company.

If you do not have insurance, payment is required in full at the time of service. We do not bill travel insurance plans or plans outside the United States. Payment is required at the time of service from patients presenting this type of insurance. If you are not on a plan that we contract with, we will collect in full at the time of service. We only accept credit card or cash as a method of payment. We do not make exceptions to this policy. We do not accept checks. We do not take liens of any kind. Patient due account balances over 28 days may be subject to a service charge. Accounts over 60 days past due are considered delinquent and will be sent a letter of collection and given 14 days to settle the account before being sent to a collection agency.

We have a 24 hour cancellation policy. If you cancel your appointment less than 24 hours before its scheduled time or if you do not show up for your appointment you will be charged a $55.00 fee.

Release of Information Policy

It is our obligation and policy to maintain the confidentiality of all patient information, including, but not limited to medical records information. To protect each patient's right to privacy and due to HIPPA regulations; we need your written authorization to speak to any family member, including a spouse, child, parent or other relative or conservator regarding your medical condition. Please provide the names below of any person you wish to have access to your medical information.

Name _____ Relation _____ Phone ( ) _____

Name _____ Relation _____ Phone ( ) _____

Name _____ Relation _____ Phone ( ) _____

Physician to release information _____ Phone ( ) _____

(Required) Address _____

(Please use other side of form for additional physicians and include address and phone number)

I have read and understand the policies of Coastal Neurological Medical Group, Inc.

I authorize payment of medical benefits to Coastal Neurological Medical Group, Inc. for any services rendered me by the physician. I authorize the release of medical information when it is requested by my insurance carrier for determination of benefits payable for related services. I recognize my financial obligation for any copay, co-insurance, deductible and non-covered services that may be required at the time of service. I acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original.

Patient Consent/Signature _____ Date _____