HUMBOLDT NEUROLOGICAL MEDICAL GROUP, INC.
PATIENT REGISTRATION

Date_____ **What pharmacy do you use?** _____

PATIENT'S NAME _____ Sex: M F Birth Date_____ Age_____

*Parent/Guardian (if under 18)*_____ *Parent/Guardian Birth Date:* _____

Street Address_____ Mailing Address_____

City_____ State_____ Zip_____

Home Phone _____ Social Security # _____ E-mail _____

Message Phone_____ Driver's License #_____ Marital Status M S D W

Patient's Employer_____ Occupation_____

Employer's Address_____ Work Phone_____

Please fill out your spouse's information (if applicable). This is important for both health and billing purposes. Thank you.

Spouse's Name_____ Social Security #_____

Spouse's Date of Birth_____ Employer_____ Occupation_____

Is this a **work related injury**? Yes No If Yes, is a first report on file? Yes No Date of Injury_____

Worker's Comp Insurance Name_____ Claim #_____

Worker's Comp Address_____ Adjuster's Name_____

Is this an injury from a **motor vehicle accident**? Yes No If yes, Date of Injury_____

Is the case being litigated? Yes No If yes, Attorney's Name_____

Referring Physician _____ Your Primary Doctor/Family Physician _____

Caregiver or Care Home Name *(if applicable)*: _____ Phone: _____

Date of your last: MRI_____ CT Scan_____ X-ray_____ EEG_____ Ultrasound_____

INSURANCE INFORMATION Circle <u>all</u> methods of payment that apply.

Private Insurance Worker's Comp Insurance (see above) Motor Vehicle Accident Insurance (see above)
Medicare Medi-Cal/CMSP None Other_____

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Name_____	Name_____
Policy_____	Policy_____
Group#_____	Group#_____
Address_____	Address_____
Name of Insured_____	Name of Insured_____

ASSIGNMENT AND MEDICAL RECORDS RELEASE

I hereby assign directly to Humboldt Neurological Medical Group, Inc. (HNMG) all medical benefits, if any, otherwise payable to me for services rendered by them. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize HNMG to release all medical and billing information necessary to secure the payment of benefits to my insurer(s) and to my other treating physician(s). I authorize the use of this signature on all my insurance forms.

Signature of Patient/Insured_____ Date_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Humboldt Neurological Medical Group, Inc.(HNMG) for any services furnished to me by them. 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 to HNMG and authorizes release of medical information necessary to pay for my services. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on any 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, HNMG agrees to accept the charge determination of the Medicare carrier as the full charge, and I will be responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Patient/Insured_____ Date_____

Revised 7-14-11