

# Neurology & Acupuncture Clinic, PLC

Office Use Only (check one)  New Patient  Est./New Patient  Info Change Recp Name: \_\_\_\_\_ Account # \_\_\_\_\_

## PATIENT INFORMATION

Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
(Physical Address only, no P.O. Boxes)

Age: \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex  Female  Male Marital Status: \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ E-mail Address \_\_\_\_\_

Patient Status:  Employed  Unemployed  Student  Retired Patient's social security # \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Work Phone # \_\_\_\_\_

Patient's Relationship to Responsible Party  Self  Spouse  Child  Other \_\_\_\_\_

If patient is a minor the responsible party information must be completed, otherwise skip

## RESPONSIBLE PARTY INFORMATION

Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Employer's # \_\_\_\_\_

## PRIMARY INSURANCE COVERAGE

(Please give insurance card and photo ID to receptionist)

Insurance Company Name \_\_\_\_\_ Ins Co. Phone \_\_\_\_\_

Policy Holders Name \_\_\_\_\_ Effective Date \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security number \_\_\_\_\_

## SECONDARY INSURANCE COVERAGE

Insurance Company Name \_\_\_\_\_ Ins Co. Phone \_\_\_\_\_

Policy Holders Name \_\_\_\_\_ Effective Date \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security number \_\_\_\_\_

## EMERGENCY CONTACT

In Case of emergency, please notify \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Relationship \_\_\_\_\_

I AUTHORIZE Neurology & Acupuncture Clinic to release any medical information necessary to submit my insurance claims or to notify others as required. I request that my insurance companies pay benefits directly to Neurology & Acupuncture Clinic. I understand that Qingyan Zhu, MD will refund any overpayment. I understand that I am financially responsible to Neurology & Acupuncture Clinic for all services received and that finance charges may be assessed for charges not paid according to Neurology & Acupuncture Clinic policy. I understand that I am responsible to pay all expenses incurred in collecting unpaid fees, including 33 1/3% attorneys fee of unpaid balance. It is my ultimate responsibility to collect benefits from my insurance companies. I take full responsibility for assuring that my insurance companies are properly notified in the event second opinions, pre-certifications, or pre-admission authorizations are required prior to services rendered.

Signed \_\_\_\_\_ Date \_\_\_\_\_