

LONG ISLAND NEUROSCIENCE SPECIALISTS

Patient Information Sheet

NAME: _____ DATE OF BIRTH: ____/____/____
(Last) (First) (Middle Initial)

SEX: _____ MARITAL STATUS: _____ AGE: _____ SS#: _____

ADDRESS: _____

STREET ADDRESS OR PO BOX _____ CITY _____ STATE _____ ZIP _____

HOME TEL#: (____) _____ WORK TEL#: (____) _____ CELL PH#: (____) _____

EMERGENCY TEL#: (____) _____ REFERRING DOCTOR: _____

PRIMARY CARE PHYSICIAN: _____ CARDIOLOGIST: _____

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PRIVATE INSURANCE _____ WORKER COMP _____ NO-FAULT _____ MEDICARE/MEDICAID _____

DO YOU CURRENTLY HAVE AN OPEN NO FAULT OR WORKER'S COMPENSATION CASE? YES NO

Insurance carrier name: _____

Does your insurance require a co-pay? YES NO Amount of co-pay? \$ _____ **(DUE AT TIME OF VISIT)**

Does your insurance require a referral? YES NO

MEDICARE PATIENT'S ONLY PLEASE SIGN:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Long Island Neuroscience Specialists for services furnished to me by the provider. 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 of the benefits payable for related services.

Patient's Signature: **X** _____ Date: ____/____/____

PATIENT'S USING OUT-OF-NETWORK BENEFITS PLEASE READ AND SIGN:

I am aware that Dr. Sumeer Sathi / Dr. Steven P. Leon / Dr. Meeru Sathi-Welsch do(es) not participate with my Insurance. The office policies regarding out-of-network benefits have been explained to me.

Patient's Signature: **X** _____ Date: ____/____/____

PATIENT EMPLOYMENT INFORMATION

Occupation of patient: _____

PATIENT EMPLOYER: _____ EMPLOYER TELE#: (____) _____

Employer Address _____
STREET ADDRESS CITY STATE Zip

AUTHORIZATION RELEASE/ASSIGNMENT OF BENEFITS

I authorized the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of the original. Also, I hereby authorize Long Island Neuroscience Specialists to apply for benefits on my behalf for covered services rendered by them. I request that payment from my insurance company be made directly to Long Island Neuroscience Specialists. This authorization may be revoked by either me or my insurance company at any time in writing. I take responsibility for payment of any services rendered by Long Island Neuroscience Specialists.

Patient's Signature: **X** _____ Date: ____/____/____