SOUTHWEST NEUROLOGY, P.A.

Patient Registration Form

Patient Name: _____ Date of Birth: _____/_____/_____
Patient's home address: _____
City: _____ State: _____ Zip: _____ (H) phone _____
Patients SSN (required) _____/_____/_____ (C) phone _____
Patient e-mail: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor

☐ Retired ☐ Unemployed ☐ Disabled
Employer: _____(W) phone: _____Ext:_____

Primary Care Doctor: _____

Who can we thank for referring you to our office? Website ___ Facebook ___ Insurance ___
Friend or Family Member _____ Referring Physician _____

Primary Insurance Information

Insured Name: _____ Relationship to patient: ☐ same ☐ spouse ☐ parent
Birthdate: ____/_____/_____ Group Employer Name: _____
Insurance Co. Name: _____ Group # _____ ID# _____

Supplemental Insurance Information

Insured Name: _____ Relationship to patient: ☐ same ☐ spouse ☐ parent
Birthdate: ____/_____/_____ Group Employer Name: _____
Insurance Co. Name: _____ Group # _____ ID# _____

Work Compensation/ Accident/ Injury Information

Date of Injury: _____ Claim #: _____
Insurance Co. Name: _____ Adjuster name: _____
Adjuster phone # : _____
Address for claims: _____
City, State, Zip:_____

Consent for Treatment: I authorize Southwest Neurology, PA to perform such examinations, treatments, laboratory tests, and to administer such medications as, in his opinion, deemed necessary or advisable for my care.
Release of Medical Records: In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical records may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here.
Insurance Authorization: I authorize release of any information concerning my (or my child's) healthcare, advice, and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also herby authorize payment of insurance benefits otherwise payable to me directly to the doctor.
Responsibility of Payment: We make every attempt at verifying your benefits for possible services that may be provided, however the benefits that are quoted from your insurance are not a guaranty of payment. If your insurance does not cover all of the visit charges, you are responsible for any remaining balance. Payment is due at the time of service.
No Show Policy: 24 Hour notice must be given to cancel your appointment; otherwise a $25 no-show fee will be charge for confirmed appointments.
Walter Taylor, M.D. does have ownership interest in Lake Pointe Hospital but as a patient you do have the right to choose the provider for your health care services. Therefore, you have the option to use a health care facility other than Lake Pointe Hospital and will not be treated differently by our office or providers.

_____ _____

Signature of patient or guardian if patient is a minor **Date**