FLORIDA Neurology Group

PATIENT REGISTRATION – Welcome To Our Office

Please Print

PATIENT LEGAL NAME: LAST	FIRST:		M.I.
Social Security # / /	Sex ☐Female ☐ Male	Date of Birth / /	
Home Address:			Apt.#
City	State	Zip	
Alternative/Northern Address			Apt.#
City	State	Zip	
Months of the Year you are at your Northern Address - from : / /		to: / /	
Patient Phone #	Cell #	Work #	
Email:	Marital Status: ☐ M ☐ D ☐W ☐S		

Due to Healthcare Reform guidelines, Florida Neurology Group is requesting the following information:

Ethnicity: ☐Non-Hispanic ☐ Hispanic

Race: ☐American Indian/Eskimo ☐Asian ☐Black ☐Caucasian ☐Native Hawaiian/Other Pacific Islander ☐Unknown/No response

Primary Language:

Spouse's Name**:**	
Referring Physician (First and Last Name)	Primary/Family Physician (First and Last Name)
Employer/Company:	Employer's Phone#
Emergency Contact: / Relationship to the patient: / Phone #	
If not referred, how did you find out about us?	

Is your appointment related an Auto Accident? **Yes ☐ Date of Injury_____ No ☐**	**Is your appointment related to an injury at work?** **Yes ☐ Date of Injury_____ No ☐**
Do you reside in a Nursing Home Facility? Yes☐ No☐	Do you reside in an Assisted Living Facility? Yes☐ No ☐
Name of Facility:	Phone #

Co-payments are due at time of service. There will be a $20.00 service charge if co-payments are not paid at time of service. Initial_____

A collection agency will take over a delinquent account if not paid in 45 days. If your account is placed with a collection agency, you will be responsible for all costs of collection. The rate charged by the collection agency is 50% of the total amount owed plus a $25.00 placement fee. These additional charges will be the patient's responsibility. Should the account be moved to Small Claims, you will be responsible for all additional costs (Court costs, Attorney fees, Collection Agency fees, etc.) Initial _____

This certifies all information given on this form to be true and accurate and I understand and agree to Florida Neurology Group's Co-payment and Financial Policy.

X_____ _____ _____

Please SIGN Guarantor Name | Please PRINT Guarantor Name | Date

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Cancellation and No Show Policy:

- If you must cancel a scheduled appointment, please call 24 hours in advance so that other patients may use your vacated appointment. Cancellations should be called to (239) 936-3554.
- Patients who cancel an appointment without a 24 hours advance notice will be considered as a **Late Cancellation.**
- Patients who do not show up for their appointment without a 24 hours advance notice will be considered as a **No Show.**
- Patients that arrive more than 15 minutes late for their appointment, the appointment will be cancelled and considered a **No Show**.

Patients who make a Late Cancellations or No-Show will be subject to a prepayment fee equal to your co-pay or $50.00. All prepayment fees must be paid in full by cash or credit card before the next appointment is scheduled.

Patient Signature:_____ Date:_____

Florida Neurology Group Payment Agreement Conditions

For the self-pay patient:

I understand and acknowledge that I am responsible for full payment of services rendered to me by all healthcare providers of Florida Neurology Group, P.L. and understand and acknowledge that any amount(s) which are designated a "patient responsibility" are payable at the time the service is provided. Should any separate payment arrangement(s) be established as my responsibility that are not kept current, I agree to assume any necessary Fees involved in the collection of any remaining balance should it become delinquent.

Patient Signature:_____ Date _____

For the patient with Insurance coverage:

I understand and acknowledge that Florida Neurology Group, P.L. will file a claim(s) for insurance payment(s) with only those insurance companies that Florida Neurology Group, P.L. participates as a provider. I agree to pay for any non-covered services, co-payment or deductibles which are considered as a "patient responsibility" under the conditions of my policy at the time the service is provided.

Should my insurance carrier later determine that additional costs are not covered under the conditions of my policy, and I am designated as the responsible party for such services, any remaining balance will be billed to me and I will pay the remaining balance upon receipt of billing. I agree to assume any necessary fees involved with the collection of this account should it become delinquent.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits for any services rendered to be paid directly to the provider or the party that accepts assignment.

Patient Signature:_____ Date _____

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign below to acknowledge receipt of the Notice, or select the "Chooses not to receive a copy.." below and sign to acknowledge your choice.

☐ I have been provided a copy of Florida Neurology Group, P.L.s' Notice of Privacy Practices.

☐ I choose not to receive a copy of Florida Neurology Group, P.L.s' Notice of Privacy Practices and acknowledge that the information is available on their website, http://fngmd.com/patient-resources.php

Patient Signature:_____ Date _____

☐Patient was offered copy of and refused to accept delivery of the Notice of Privacy Practices information.
☐Patient accepted delivery of copy but refused to sign form to acknowledge Receipt of Notice of Privacy Practices
Staff Member Signature_____ Date_____