

HUMBOLDT NEUROLOGICAL MEDICAL GROUP, INC.
PATIENT REGISTRATION

Date _____

PATIENT'S NAME _____ Birth Date _____ Age _____

Parent or Guardian (if patient is a minor) _____ Sex M F

Street Address _____ Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Social Security # _____

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

Patient's Employer _____ Occupation _____

Employer's Address _____ Work Phone _____

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 _____

Date of your last: MRI _____ CT Scan _____ X-ray _____ EEG _____ Ultrasound _____

INSURANCE INFORMATION Circle all 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 _____