THE NEUROLOGICAL CARE CENTER OF MONTGOMERY, P.C.
1315 MULBERRY STREET
MONTGOMERY, AL 36106
PLEASE PRINT **REFERRED BY:**

PATIENT: THIS SECTION REFERS TO **PATIENT ONLY**

NAME	SEX	AGE	DOB	MARITAL STATUS (CHOOSE ONE) ____SINGLE ____MARRIED DIVORCED SEPARATED
ADDRESS	SS#			
CITY **STATE** **ZIP**	**EMPLOYER**			
HOME PHONE ( )	ADDRESS			
WORK PHONE ( )	CITY STATE ZIP			
CELL PHONE ( ) EMERGENCY CONTACT AND PHONE				

BILLING: PLEASE COMPLETE IF PERSON RESBONSIBLE FOR BILLING IS OTHER THAN ABOVE PATIENT

NAME	RELATIONSHIP TO PATIENT	SS#
ADDRESS	OCCUPATION	
CITY STATE ZIP	EMPLOYER	
HOME PHONE ( )	ADDRESS	
WORK PHONE ( )	CITY STATE ZIP	

INSURANCE NO COVERAGE _____	BLUE SHIELD _____	UHC _____	TRICARE _____	MEDICARE _____	MEDICAID _____	WORKMAN'S COMP _____	CHAMPUS _____	OTHER _____

Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information of both carriers. Please show all numbers on your card(s).

Primary carrier	**Secondary carrier**
name_____	**name**_____
address_____ _____	**address**_____ _____
Insured_____ _____ (name on ID card)	Insured_____ _____ (name on ID card)
Relationship to patient ___ self ____ spouse ____child ____other	Relationship to patient ____self ____spouse ____child ____other
Insured ID No._____	Insured ID No._____
Group No _____ or company name _____	Group No _____ or company name _____
Effective date: _____	Effective Date: _____

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carriers.

MEDICARE
Name of Beneficiary_____ HI Claim Number _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to _____ for any services furnished me by that physician. I authorize any holder of medical information about my 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 hereby authorize Medicare to furnish the above name doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act.

COMMERCIAL
I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED IN THE CLAIM.
I understand I am financially responsible for any balance not covered by my insurance carrier

A copy of this signature is as valid as the original.

Signature_____