ACCESS NEUROLOGY CONSULTANTS

4660 Kenmore Ave, Suite 408, Alexandria, VA 22304

Last Name:	First Name:	MI:
Home Address Street:	Social Security Number	Date of Birth
City, State, Zip	Marital Status	Home Telephone
Cell Phone	Email	
Emergency Contact	Relationship Home Phone	Cell Phone

Insurance Information

Name of Insurance Policy Holder		Policy Holder SSN	Policy Holder DOB
Address (street, City, State, Zip)		Home Phone:	Work Phone:
Primary Health Insurance	Policy Holder Name	Relationship to pt	Plan Type
Insurance Co Address	ID Policy #	Group #	Effective Date
Secondary Health Insurance	Policy Holder Name	Relationship to pt	Plan Type
Insurance Co Address	ID Policy #	Group #	Effective Date

Primary Care Doctor____

Referred by ____

Pharmacy Name, address, zip code, and telephone number:

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FOR WORK RELATED INJURY:

Date of Injury____
Employer ____
Workers Compensation Insurance Carrier________________________

AUTHORIZATIONS, AGREEMENTS and ACKNOWLEDGMENTS:

Authorization for Assignment of Benefits & Release of Information:

I authorize Neural Network PLLC DBA Access Neurology Consultants to bill my health insurance carrier or workman's comp insurance and further authorize payment directly to this entity. I further authorize the release of medical information to Access Neurology Consultants, required by my insurance carrier in order to determine benefits to which I am entitled.

Financial Agreement:

I assume financial responsibility for and agree to make payment in full to Access Neurology Consultants for services or medical supplies provided to me if the claim is denied because of inaccurate insurance information. I also agree to make payments in full if the claim is denied for untimely filing because of delay in responding to my insurance carrier. Payment is to be made within 30 days of statements with settlement in full. I certify that the information provided is true, accurate, and complete to the best of my knowledge I understand that should an account be placed with a collection agency or attorney for collection, then I agree to be responsible for all costs incurred in the collection of my account, including but not limited to attorneys' fees, collection agent fees, interest at 1.5% per month and all court costs.

Acknowledgement of Receipt of Notice of Privacy Practices:

I have been given an opportunity to review the Notice of Privacy Practices for this office (available at our front desk).

Financial Practices:

There is a no show fee for Office Visits (24 business hours notice required) of $50
There is a no show fee for Office Procedures (EMG/EEG/Botox etc) of $100

Prescription Refills:

If refills are desired, please go to your pharmacy and request that they send an *electronic refill request* or *fax* to the office during normal business hours. No prescription refills will be provided without an office appointment for controlled substances such as opioids, benzodiazepines, stimulants, and some hypnotic and other pain medications. Patients will be given sufficient refills to make it to the next appointment. In the case of schedule 2 medications, no refills are allowed by law.

Name of Policy Holder, Patient, or Parent/Guardian

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Signature of Policy Holder, Patient, or Parent/Guardian

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Date:

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