The Clinic for Neurology, P.A.
185 Chateau Drive, Suite 301
Huntsville, AL 35801

INITIALS	OFFICE USE ONLY
ENCOUNTER NO.	

Date: ____________________________

PATIENT'S NAME IN FULL (NO NICKNAMES) Last Name First	MARITAL: S / M / W / D / SEP	DATE OF BIRTH	AGE	SEX

RACE: ❑ AFRICAN AMERICAN ❑ ASIAN ❑ CAUCASIAN / WHITE ❑ NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER ❑ AMERICAN INDIAN / ALASKA NATIVE ❑ DECLINED ❑ UNKNOWN

PRIMARY LANGUAGE: ❑ ENGLISH ❑ SPANISH ❑ OTHER ______________	ETHNICITY: ❑ HISPANIC ❑ NON-HISPANIC ❑ DECLINED ❑ UNKNOWN

ADDRESS	CITY , STATE & ZIP	EMAIL

SOCIAL SECURITY NO.	HOME PHONE NO. ( )	BUSINESS PHONE NO. ( )	CELL PHONE NO. ( )

PREFERRED METHOD OF COMMUNICATION: ❑ PHONE ❑ MAIL ❑ EMAIL

OCCUPATION (INDICATE IF STUDENT)	EMPLOYER	HOW LONG EMPLOYED?	RELIGION (OPTIONAL)

EMPLOYER'S ADDRESS	CITY, STATE & ZIP

HUSBAND, WIFE, PARENT OR GUARDIAN NAME	DATE OF BIRTH	SSN

EMPLOYER OF ABOVE NAME	CITY & STATE	ZIP CODE	BUSINESS PHONE NO. ( )

EMERGENCY CONTACT/RELEASE OF INFORMATION	RELATIONSHIP	HOME TELEPHONE NO. ( )	BUSINESS PHONE NO. ( )

REFERRING PHYSICIAN			
ADDRESS	CITY & STATE	ZIP CODE	PHONE ( )
FAMILY PHYSICIAN			
ADDRESS	CITY & STATE	ZIP CODE	PHONE ( )

PERSON RESPONSIBLE FOR BILL: ______________________________

IF OTHER THAN PARENT, S.S.# ______________________________

ADDRESS OF RESPONSIBLE PARTY ______________________________

PRIMARY INSURANCE CO.	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY
CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:	
SECONDARY INSURANCE CO.	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY
CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:	
OTHER INSURANCE	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY
CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:	

SERVICES CAN BE CHARGED TO YOU THROUGH MASTERCARD, VISA OR DISCOVER

OVER

ADDITIONAL PERSON FOR THE RELEASE OF INFORMATION

Purpose: To ensure authorization that releases CFN to speak with additional persons regarding patient care.

I, ______________________________________, patient of CFN, authorize the following individuals to be able to discuss my care and/or appointments at The Clinic for Neurology, P.A. with my physician and clinical staff, as well as any insurance or billing issues.

____________________	_________________	____________________	_________________
Name	Relationship	Name	Relationship
____________________	_________________	____________________	_________________
Name	Relationship	Name	Relationship

AUTHORIZATION FOR SERVICES

The signature below serves as authorization for services rendered by The Clinic for Neurology, P.A. for the above named patient, and release of information necessary to file insurance; and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by the insurance carrier - a copy of the signature is as valid as the original. Authorization is continuing while patient is under care of The Clinic for Neurology, P.A. or until patient revokes authorization.

ACKNOWLEDGEMENT/AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

The signature below serves as authorization for The Clinic for Neurology, P.A. to release or receive medical information for the purpose of patient referral. I understand and have been offered a CFN Notice of Privacy Practices that provides a more complete description of information uses and disclosures; that I have the right to review the notice prior to signing the acknowledgement; that CFN reserves the right to change its notice and practices. A copy of this signature is as valid as the original. Authorization is continuing while the patient is under care of The Clinic for Neurology, P.A. or until patient revokes authorization.

Signature: ____ Date: ____________________