Current Patient Information - Please Print

Last Name _____ First Name _____ M.I. _____

Birth Date _____/_____/_____ Gender: ☐ M ☐ F SS# _____

Address _____

City _____ ST _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Guarantor Information (to whom statements are sent)

Last Name _____ First Name _____ M.I. _____

Relationship to Patient: _____ Birth Date _____/_____/_____ SS# _____

Address (if different from patient): _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact Information:

Name: _____

Relationship to Patient: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Primary Insurance Information

Policy Holder (if other than patient):

Last Name _____ First Name _____ M.I. _____

Address _____

City _____ ST _____ Zip _____

Birth Date _____/_____/_____ Gender: ☐ M ☐ F Employer Name: _____

Policy Information: Patient's relationship to policy holder: _____

ID/Certification No.:_____ Policy/Group No.: _____

Secondary Insurance Information

Policy Holder (if other than patient):

Last Name _____ First Name _____ M.I. _____

Address _____

City _____ ST _____ Zip _____

Birth Date _____/_____/_____ Gender: ☐ M ☐ F Employer Name: _____

Policy Information: Patient's relationship to policy holder: _____

ID/Certification No.:_____ Policy/Group No.: _____

ADVANCED NEUROLOGY AND SLEEP | Advanced HEALTH

ASSIGNMENT AND RELEASE

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the physician to release any medical information required to process this claim.**
- **I authorize my provider's office to contact me by telephone to remind me of my appointments.**
- **I authorize Advanced Neurology & Sleep to download my current medications for purposes of insurance payment.**
- **I have received a Notice of Privacy Practice, Notice of Patient Rights and Responsibilities**
- **I hereby consent to treatment by my Advanced Neurology & Sleep providers. I authorize Advanced Neurology & Sleep to release to referring or subsequent healthcare provider, reports of my medical condition that will assist him or her in my continued care and as needed to process claims and for general health care operations, which may include use of an electronic health information exchange.**
- **I authorize the physician to release any immunizations to the Tennessee Web Immunization System.**

I understand that once my health information is disclosed to a third party, that party may disclose my information to other parties and any redisclosures of my health information by a third party may no longer be protected under federal or state privacy laws

I understand that protected health information may include information relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection.

I understand that this consent will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this consent to the Practice. However, any disclosures that occurred prior to the date of the revocation will not be affected.

By signing this consent, I authorize Advanced Neurology & Sleep and its affiliates to disclose my protected health information to the following individual(s) for the purpose of keeping them informed about my condition and treatment, and I understand that these disclosures are in addition to those disclosures described in the Notice of Privacy Practices:

Name: _____ Relationship: _____

Method of Communication: _____

Name: _____ Relationship: _____

Method of Communication: _____

May we contact you regarding your protected health information, health status, appointments, and test results?

☐ Yes, you may contact me by e-mail; my address is: _____

☐ No, do not contact me by email for this purpose.

☐ Yes, you may contact me by phone; my daytime phone numbers are: (_____)

_____ ☐ Yes, you may contact me at the following fax number (_____)

_____

May we leave a message regarding your protected health information at the numbers you provided above? ☐ Yes ☐ No

Signed: _____ Date:_____

Revised 07.19.2017