

Associates In Neurology, P.C.

2755 Middlebelt Road • Farmington Hills, Michigan 48334

M.L. Elkiss, D.O., F.A.C.N. • B.M. Silverman, D.O., F.A.C.N. • M.A. Kachadurian, D.O. • M.B. Silverman, D.O. • N.M. Burns, M.D.

Patient's Name (Please Print)	SS#	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of Birth
Street Address	City & State		Zip Code	Home Phone # ()	
Patient's Employer	Occupation		How Long?	Bus. Phone #	
Employer's Street Address	City & State		Zip Code	Bus. Phone Ext.	
Patient's Driver License	Spouse's Name		Spouse's Birth Date		
Spouse or Parent's Employer	Occupation		How Long?	SS#:	
Employer's Street Address	City & State		Zip Code	Phone #	
Medication			Allergies		

~ Emergency Contact Other Than Spouse ~

Name	Relationship	Phone #:
Address	City & State	Zip Code
Please Print the Doctor's Name Who Referred You	Street Address	
City State Zip Phone #:	Whom May We Thank For Referring You If Not A Physician?	

Are you retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Retirement:	Is Your Spouse Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Retirement:
Are you working? <input type="checkbox"/> Yes <input type="checkbox"/> No	How Long Have You Been Off Work?	Is This Worker's Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please Complete Additional Form
Is This Auto Related? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please Complete Additional Form		
Attorney's Name			Phone #:
Address		City State	Zip

Insurance Information: Please provide patient's primary and spouse's secondary insurance card. Patient's insurance is primary.

Primary Insurance	Secondary Insurance
Group #:	Group #:
Service #:	Service #:
Contract #:	Contract #:
Policy Holder's Name:	Policy Holder's Name:

~ Please Complete Other Side ~

Consent for Purposes of Treatment, Payment and Healthcare Operations

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by *Associates in Neurology, P.C.* for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of neurology. I understand that *Associates in Neurology, P.C.* may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my protected health information for the above stated purposes. (My signature on this document is evidence of this consent.)

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. *Associates in Neurology, P.C.* is not required to agree to the restrictions that I may request. However, if *Associates in Neurology, P.C.* agrees to a restriction that I request, the restriction shall be set forth in writing and signed by each party.

I understand that I have a right to review *Associates in Neurology, P.C.* Notice of Privacy Practices prior to signing this document. *Associates in Neurology, P.C.* Notice of Privacy Practice has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of *Associates in Neurology, P.C.* This Notice of Privacy Practices also describes my rights and *Associates in Neurology, P.C.* duties with respect to my protected health information.

Associates in Neurology, P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, at any time, except to the extent that *Associates in Neurology, P.C.* or Mitchell L. Elkiss, D.O., F.A.C.N., Bruce M. Silverman, D.O., F.A.C.N., Mark A. Kachadurian, D.O., Mark B. Silverman, D.O., and Norman M. Burns, M.D., has taken action in reliance on this consent.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

If outpatient services are needed (ex: MRI, CT Scan, X-Ray), the patient is responsible for any prior authorization required by the insurance company. All professional services will be billed to your insurance carrier. We do accept assignment of the insurance carriers with which *Associates in Neurology, P.C.* participate, however, all co-pays must be paid at the time of service. Blue Cross Master Medical and Blue Cross patients with no office coverage must pay on the date of service.

I have read the above policies and agree to them. I authorize *Associates in Neurology, P.C.* to provide me with neurological services and to furnish information to my insurance company regarding my neurologic treatment, worker's compensation/auto carrier concerning my injury and treatment. I authorize payment of benefits directly to *Associates in Neurology, P.C.* for services rendered to me and/or my dependents. I understand that I am financially responsible for any co-payments or charges not covered by my insurance company.

Signature

Date

I authorize *Associates in Neurology, P.C.* to leave messages regarding my medical appointments, condition, or test results, etc. with:

Members of my household _____ Yes _____ No On an answering machine _____ Yes _____ No

Please initial: _____