Southlake Neurology and Neurophysiology Clinic, PLLC
321 W. SOUTHLAKE BLVD, SUITE 180 SOUTHLAKE, TX 76092
PH: 817-421-2905 FAX:817-416-7284

Patient Demographics & Insurance

Patient Information

Patient Last Name	First Name	Middle Name	Alias Name	
Address (Street or Box)		City	State	Zip
Home Phone ☐ Primary Number	Work Phone ☐ Primary Number	Mobile Phone ☐ Primary Number ☐ Text appointment reminders		
Email		Marital Status Single ☐ Married ☐ Divorced ☐ Widowed ☐		
Social Security Number	Date of Birth	Sex Male ☐ Female ☐	Driver's License # State Exp. Date	
Employer Name		Employer Address		
Primary Physician Name	Phone #	Referring Physician Name	Phone #	
Preferred Pharmacy	Cross Street and City	How did you hear about Southlake Neurology?		

Complete this section only if the patient above is a minor

Responsible Party

Responsible Party Last Name	First Name	Middle Name	Alias Name	
Address (Street or Box)		City	State	Zip
Home Phone	Work Phone	Mobile Phone		
Email		Marital Status Single ☐ Married ☐ Divorced ☐ Widowed ☐		
Social Security Number		Sex Male ☐ Female ☐	Date of birth	

Insurance & Subscriber Information

Primary Insurance Company		Effective Date
Claims Mailing Address (Street or Box)		
City	State	Zip
Policy ID Number	Group ID Number	
Subscriber Name (policy holder)	Date of Birth	
Subscriber Social Security #	Relationship to Patient	
Subscriber Employer	Work Phone #	
Subscriber Employer Address (Street or Box)		
City	State	Zip

Secondary Insurance Company		Effective Date
Claims Mailing Address (Street or Box)		
City	State	Zip
Policy ID Number	Group ID Number	
Subscriber Name (policy holder)	Date of Birth	
Subscriber Social Security #	Relationship to Patient	
Subscriber Employer	Work Phone #	
Subscriber Employer Address (Street or Box)		
City	State	Zip

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Approved HIPAA Contacts

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian**.

Please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like to list as your **Emergency Contact** in the event an emergency situation was to take place at our office.

_____ _____ _____
(1) Contact Name Relationship to Patient Contact Phone Number

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

_____ _____ _____
(2) Contact Name Relationship to Patient Contact Phone Number

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

- ***Consent for Medical Treatment:***

I hereby give permission to Southlake Neurology and Neurophysiology Clinic, PLLC its providers and employees for medical treatment for myself or for the patient (if I am the patient's representative, e.g. parent, guardian, or medical power of attorney). I understand that this will involve taking a medical history, performing a physical examination, possibly removing articles of clothing for the examination, forming a clinical impression, making a treatment plan, ordering or performing diagnostic studies, communicating with other persons involved in the medical care, prescribing medications, and ordering medical treatments.

All disability and insurance forms filled out by a physician are subject to an appointment and a charge of $25.

Print Patient Name: _____

Signature Patient/Guardian: _____ Date: _____

- ***Acknowledgement of Notice of Privacy Practices:***

Southlake Neurology and Neurophysiology Clinic, PLLC has provided its Notice of Privacy Practices to me. Federal law requires us to ask you to sign this statement to confirm that we provided you with our Notice of Privacy Practices.

Print Patient Name: _____

Signature Patient/Guardian: _____ Date: _____

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- **Financial Responsibility:**

I hereby authorize payment of medical benefits directly to Southlake Neurology and Neurophysiology Clinic, PLLC (hereinafter "Southlake Neurology"). Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical claim. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Southlake Neurology in full. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of Southlake Neurology, if any. **In the event my insurance does not pay the amount billed or there is a balance on my account, I will be financially responsible for the amount or any other outstanding balance.**

Print Patient Name: _____

Signature Patient/Guardian: _____ Date: _____

- ***Scheduled Appointments***:

We understand that delays can happen however we must try to keep other patients and providers on time. **If a patient is 15 minutes past their scheduled time we will need to reschedule the appointment.**

Print Patient Name: _____

Signature Patient/Guardian: _____ Date: _____

- ***Cancellation/No Show Policy for Appointment:***

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fee based on your type of visit; this will not be covered by your insurance company. This fee must be paid in full before you are seen in the office again. A total of three (3) no shows will be considered grounds for automatic termination from the practice.

Type of Visit	*Fee Charged to Account*
New Patient	$50.00
Follow-up Visit	$30.00
EMG	$100.00
EEG	$100.00
Sleep Study	$250.00

Print Patient Name: _____

Signature Patient/Guardian: _____ Date: _____

08/2018