

**Neurology Medical Group of Diablo Valley, Inc.  
REGISTRATION FORM**

Today's date:	Primary Care Physician:
---------------	-------------------------

**PATIENT INFORMATION**

Patient's last name:	First:	M.I.:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one)
Do you go by any other name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes: _____		<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid
Social Security No.:	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Street Address:	Apt. No.:		Home phone: (    )		
			Cell phone: (    )		
Email Address:	City:	State:	ZIP Code:		
Employer:	Occupation:		Employer phone: (    )		

Emergency Contact:	Emergency Contact Phone:
--------------------	--------------------------

**SPOUSE OR PARENT/RESPONSIBLE PARTY INFORMATION**

Last name:	First:	M.I.:	Relationship to patient:		
Social Security No.:	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Street address:	Apt. No.:		Home phone: (    )		
			Cell phone: (    )		
P.O. box:	City:	State:	ZIP Code:		
Employer:	Occupation:		Employer phone: (    )		

**PRIMARY INSURANCE INFORMATION**

(Please give insurance card to the receptionist.)

Please indicate primary insurance	<input type="checkbox"/> Medicare	<input type="checkbox"/> John Muir	<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Blue Shield	<input type="checkbox"/> Other (list)
Subscriber's name:	Subscriber's S.S. no.:	Subscriber's DOB: / /	Policy no.:	Effective date:	Co-payment: \$
Subscriber's Employer:					
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

**SECONDARY INSURANCE INFORMATION**

(Please give insurance card to the receptionist.)

Please indicate secondary insurance	<input type="checkbox"/> Medicare	<input type="checkbox"/> John Muir	<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Blue Shield	<input type="checkbox"/> Other (list)
Subscriber's name:	Subscriber's S.S. no.:	Subscriber's DOB: / /	Policy no.:	Effective date:	Co-payment: \$
Subscriber's Employer:					
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

**Insurance Payment Authorization and Release:** I hereby authorize my insurance benefits to be paid directly to Neurology Medical Group of Diablo Valley, Inc. and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of any information requested by my insurance company.

\_\_\_\_\_  
*Patient/Guardian signature*

\_\_\_\_\_  
*Date*

PLEASE BRING THIS FORM ALONG WITH YOUR INSURANCE CARD(S) AND APPLICABLE COPAY(S) TO YOUR APPOINTMENT. THANK YOU.

**1. Insurance Payment Authorization and Release.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. Please contact your insurance company with any questions you may have regarding your coverage. All patients must provide their insurance card(s) to the Patient Service Representative at the time of check-in. Doctors Steven Holtz, Janet Lin, Raymond Stephens, Brad Volpi, Michael Nelson, Robert Algar, Steven Schadendorf and Leslie Gillum are members of a professional corporation and have a financial interest in Neurology Medical Group of Diablo Valley, Inc. which can also perform EMG, EEG, and EP testing.

**2. Referrals, Co-payments and Deductibles.** Referrals must be presented at the time of service. All co-payments and deductibles must be paid at time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. In the event these items cannot be made at time of service, a service charge of **\$10.00** will be imposed to bill you. **For your convenience we accept Visa, MasterCard and American Express.**

**3. Non-Covered Services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers.

**4. Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you fail to provide us with the correct insurance information or notify us of changes in insurance in a timely manner, you may be responsible for the balance of a claim.

**5. Medical Records/Forms Fee Schedule.** Please allow 5-7 working days for requests for medical records and or form completion. Our Fee schedule is as follows:

<b>Personal Patient Request</b>	<b>Professional Request</b>
Complete Records- \$15.00	Treating Physicians- NO Charge
Complete Records in Storage- \$30.00	Insurance-\$25.00
Forms (Disability, DMV, Life Insurance, Etc.)- \$25.00	Legal/Subpeona-\$15.00

**6. Prescription Refills/Renewals.** To avoid duplicate prescriptions, all routine refill requests should be made by contacting your pharmacy first. Please do not wait until your prescription runs out or has expired. Allow **72 hours notice** to review your refill or renewal request. Refill and/or renewal requests will only be processed **Monday through Friday** during normal business hours. Controlled drug substance (narcotic) prescriptions must be picked up in the office and will not be refilled after hours, on weekends, or by the On-Call Physician.

**7. Appointments.** We greatly appreciate you allowing us to provide you with the best neurological care possible. Our physicians and staff know your time is important and we hope you understand the value of our time. We want to be able to provide every patient with all the attention they require. Therefore, if you are not on time for your appointment and are 15 minutes late or more, it may be necessary to reschedule for another day. Please provide us with a 24 hour notice if you will not be able to maintain your appointment or you will be charged a **\$25.00** no-show fee.

**I have read and understand the above and agree to abide by its guidelines.** A copy will be provided to you upon request.

\_\_\_\_\_  
**Signature of patient or responsible party**

\_\_\_\_\_  
**Date**

Please let us know if you have any questions or concerns.  
*Thank You*