Xabier Beristain, M.D.
Robert S. Flint II, M.D., Ph.D.
Nancy R. Frappier, M.D.
Karen L. Griffin, NP-C
Andrea L. Haller, M.D.
Virginia B. Hemelt, M.D.
Sridhar Jatla, M.D.
Kevin J. Puzio, M.D.
Susan McVey Sloss III, NP-C
Andrew J. Spoljaric III, M.D.

For office use only:
Account: ____________________
Dr.: ____________________

Patient Registration Form

Patient Name: ____________________

Sex: M F Date of Birth: ____________________ Social Security #: ____________________

Responsible Party: ____________________

Address: ____________________ City: ____________________ State: __________ Zip: __________

Home Phone: ____________________ Work/Alternate Phone: ____________________

Patient Employer: ____________________ Phone: ____________________

Address: ____________________ City: ____________________ State: __________ Zip: __________

Referring Doctor: ____________________ Phone: ____________________

Family Doctor: ____________________ Phone: ____________________

Is this a workman's compensation case? YES NO W/C Carrier: ____________________

Contact: ____________________ Address: ____________________

Claim #: ____________________ Phone: ____________________

Is this a litigation case? YES NO Attorney: ____________________

Primary Insurance:

Insurance Company: ____________________ Policy Holder's Name: ____________________

Sex: M F Policy Holder's Date of Birth: __________ Policy Holder's Relationship to Patient: ____________________

Policy Holder's Employer: ____________________ Address: ____________________ Phone: __________

Policy #: ____________________ Group #: ____________________

Is this policy through: ☐Employer ☐Agent ☐Medicare/Medicaid

Secondary Insurance:

Insurance Company: ____________________ Policy Holder's Name: ____________________

Sex: M F Policy Holder's Date of Birth: __________ Policy Holder's Relationship to Patient: ____________________

Policy Holder's Employer: ____________________ Address: ____________________ Phone: __________

Policy #: ____________________ Group #: ____________________

Is this policy through: ☐Employer ☐Agent ☐Medicare/Medicaid

Third Insurance:

Insurance Company: ____________________ Policy Holder's Name: ____________________

Sex: M F Policy Holder's Date of Birth: __________ Policy Holder's Relationship to Patient: ____________________

Policy Holder's Employer: ____________________ Address: ____________________ Phone: __________

Policy #: ____________________ Group #: ____________________

Is this policy through: ☐Employer ☐Agent ☐Medicare/Medicaid

Who should we contact in case of an emergency that lives outside your home?

Name: ____________________ Home Phone: ____________________ Work Phone: ____________________

Address: ____________________ City: ____________________ State: __________ Zip: __________

Should it be necessary to turn your account over for collection, you will be held responsible for any additional collection, court costs or attorney fees.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize treatment of the person named above, and the release of such personal information as is necessary for the completion of insurance claims from the medical records compiled during treatment and the release from all legal liability that may arise from the release of the information requested. I authorize my insurance to make payment directly to Neurology Indiana LLC.

I have requested a copy of the Neurology Indiana LLC Credit and Collection Policy.

Signature: ______________________________ **Date:** ____________________

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