

DATE: \_\_\_\_\_

**ATLANTA NEUROLOGICAL ASSOCIATES**

\*\*Patient's Full LEGAL Name: \_\_\_\_\_  
LAST FIRST MIDDLE MAIDEN

Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
MONTH DATE YEAR

Address: \_\_\_\_\_ Apt.#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Patient's Social Security Number: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's or Guardian's Name: \_\_\_\_\_

Spouse or Guardian's Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

\*\*In Case of Emergency, Please List Contact Person Other Than Above: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

\*\*Who Is Your Referring Physician?: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ Reason For This Visit? \_\_\_\_\_

===== **INSURANCE INFORMATION** =====

**PRIMARY POLICY (#1)**

Insurance Co. Name: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Is this Group Insurance? \_\_\_\_\_ Group or Employer's Name: \_\_\_\_\_

Who is Insured? Patient \_\_\_\_\_ Spouse \_\_\_\_\_ Other \_\_\_\_\_ If Insured is Spouse or Other, Please List

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
MONTH DATE YEAR

**SECONDARY POLICY (#2)**

Insurance Co. Name: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Is this Group Insurance? \_\_\_\_\_ Group or Employer's Name: \_\_\_\_\_

Who is Insured? Patient \_\_\_\_\_ Spouse \_\_\_\_\_ Other \_\_\_\_\_ If Insured is Spouse or Other, Please List

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
MONTH DATE YEAR

**WORKER'S COMPENSATION**

Please Check in with Receptionist Prior to Visit to Verify Benefits and Obtain Authorization!!!

===== **PATIENT/GUARANTOR STATEMENT** =====

I consent to the release of information about me to my insurance company, any governmental payor, or any other persons/entities as may be reasonably necessary for billing and collection purposes. I consent to the use/release of medical information about me for purposes of my further medical treatment. I also consent to the use/release of medical information about me for purposes of health care operations, for example, quality assurance activities. This consent to release medical information may be revoked in writing by me at any time and such revocation shall be effective immediately, except to the extent that the Practice has taken action in reliance upon my consent. I also understand that I am responsible for PAYMENT IN FULL for services rendered.

**I have read and I understand this document.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
Patient/Guarantor

OVER 

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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