HOUSTON NEUROLOGY ASSOCIATES

Dr. Leonard Hershkowitz **Dr. Shahin Shirzadi**

PATIENT INFORMATION (PLEASE PRINT)

Referring Dr. or Primary Care Physician: _____

I. PATIENT INFORMATION

Full Name: _____ Birth Date: _____ Age: ____ Sex: _____

Home Address: _____ Apt. No.: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone #_____Cell Phone #_____Work Phone # _____

Employer: _____

Work Address: _____City: _____ State: _____ Zip: _____

Allergies to Medications: _____ Smoker: _____ Height: _____ Weight: _____

Driver's License # _____ Social Security # _____ Marital Status: _____

Language: _____ Race: _____ Ethnicity: _____

Preferred Pharmacy Name: _____ Address: _____

_____

Phone # _____

II. EMERGENCY CONTACT

Name: _____ Address: _____

Phone #.: _____

Employer: _____ Work Phone # _____

Work Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____

III. INSURANCE INFORMATION

(Primary)

Insurance Company:_____

Address/Phone # _____

_____

Insured's Name: _____

Insured's Date of Birth: _____

Insured's Social Sec. or ID: _____

Group or Policy # _____

Employer (if group policy): _____

(Secondary)

Insurance Company: _____

Address/Phone # _____

_____

Insured's Name: _____

Insured's Date of Birth: _____

Insured's Social Sec. or ID: _____

Group or Policy # _____

Employer (if group policy): _____

IV. AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payors and/or health practitioners.

I authorize and request my insurance company to pay directly to the doctors or doctor's group any insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf that the insurance company indicates is my responsibility.

X _____ Date: _____

Signature of Patient

Late Charges Note: If I do not make a monthly payment on the balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current by making monthly payments may result in denial of additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs incurred in attempting to collect on this amount or any future outstanding balances.