RNC

ROCKFORD NEUROSCIENCE CENTER

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PATIENT INFORMATION (PLEASE PRINT) **Date** ________________________

Name ______________________________ **DOB** ___________ **Age** ____________

Address _________________________________ **Phone #** _____________________

City/State ________________________________ **Zip Code** ____________________

Social Security # ____________________ **Referring Physician:** ________________

Sex M F **Single** **Married** **Divorced** **Widowed**

INSURED'S INFORMATION

INSURED: ☐ **Self** ☐ **Parent** _______________ ☐ **Other** _________________

Address ___________________________ **City, State, Zip** _____________________

Social Security # _________________ **Birthdate** _________________ **Sex M F**

Primary Carrier: _________________________ **Group #** ____________________

Address_________________________________ **Policy #** _____________________

Secondary Carrier: _______________________ **Group #** _____________________

Address _________________________________ **Policy #** _____________________

In case of an emergency, please notify:

Name: _______________________________ **Phone#** _______________________

I hereby assign payment of medication benefits to the physician who I am seeing today. I understand that it is my responsibility to be aware of insurance benefits for the provider as outlined in my insurance plan. I authorize release of any and all medical information regarding my care for insurance or any purpose deemed ethical and appropriate by RNC. I understand that payment in full is due within 30 days. Account balances that are not paid and subsequently go to an outside collection agency will include costs incurred by that collection agency not to exceed 50% of the principle, plus attorney fees and cost of the suit.

Signature _________________________________ **Date** _____________________

EMG *24 HOUR EEG* *BOTOX* *BALANCE TESTING* *INFUSION* *NEURO PT*

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