Patient History Form

Name______________________________________

Date_______________________________________

Main symptoms_____________________________

Are Your Symptoms:

Patient Information____

Marital Status:

Occupation:____

Allergies:____

Height:___________________________ Weight_______________________________

Do You:____

Sleep Well?	Y	N	How many hours?________________
Use Alcohol?	Y	N	How much?______________________
Use Tobacco?	Y	N	How much?______________________
Caffeinated Bev.?	Y	N	How much?______________________
Street Drugs?	Y	N	How much & what?______________
Exercise?	Y	N	How much?

Past Medical History:____

Surgeries, Illnesses, or Injuries____

____

____

Family Medical History:____

Illnesses____

____

System Review:

Check the box if you have been experiencing a problem with any of the following:

Fever	Vision
Chest Pain	Arthritis
Shortness of Breath	Rash
Diarrhea	Frequent Urination
Bleeding or Bruising	Thyroid Problems
Depression	

Medications

	Medication	Dose	How OftenTaken
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

FINANCIAL POLICY

Benefits are determined once a claim is received by your insurance company. Our facility will provide the service of billing your medical insurance company; however, as the patient and/or responsible party, you are responsible for providing us with **ALL** the **CORRECT** and **COMPLETE** information regarding medical insurance coverage at the time of service. It is also the responsibility of the patient and/or responsible party to pay for all co-payments, deductibles, and/or co-insurance amounts, if required by your insurance policy. If the insurance company denies the claim for services rendered due to reasons for which we cannot appeal, you understand that the balance will then become your responsibility.

As a cash paying patient, you are aware that half of the payment for services rendered are due at the time of service and payment arrangements may be made for the remaining balance.

A non-sufficient funds (NSF) fee of $25 will be applied to any returned check and then we will only accept cash, credit card, or money order for any and all payments thereafter.

ASSIGNMENT OF BENEFITS

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare Beneficiary, to AMDx, LTD/Neurodiagnostic Laboratories, LLC and or/it's affiliated entities or otherwise at its direction.

AUTHORIZATION TO RELEASE INFORAMTION

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by AMDx, LTD/Neurodiagnostic Laboratories, LLC. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by AMDx,LTD/Neurodiagnostic Laboratories, LLC.

I HAVE READ, UNDERSTAND, AND AGREE TO THIS FINANCIAL POLICY, ASSIGNMENT OF BENEFITS, AND AUTHORIZATION TO RELEASE INFORMATION

Print Patient/Responsible Party Name:_______________________________________

Date Of Birth:____

Social Security Number:____

Patient/Responsible Party Signature:____

Date:________________________

INSURANCE FORM

PRESCRIBING DOCTOR:___________________

Type of Test Being Performed (circle one)

EMG/NCS: Full Spine Upper Series Lower Series **EEG:** Routine Ambulatory **VNG:** Routine

Patient Information:
(PO Boxes are NOT acceptable.)

Full name:____

Address:____

Apartment/Suite:________________________________

City:__________________State:____Zip:__________

Employer:____

SSN:____

Home Phone:______________________________________

Cell Phone:______________________________________

Work Phone:______________________________________

Birth Date:______________________________________

E-mail:____

Marital Status: Single / Married / Divorced / Widowed

Insured Information (If Different From Left)

Full Name:_______________________________________

SSN:____

Birth Date:______________________________________

Address:____

Apartment/Suite:________________________________

City:____________________State:____Zip:__________

Attorney (If Applicable)

Fir Name:_______________________________________

Address:____

City:____________________State:____Zip:__________

Telephone:______________________________________

Date of Loss:___________________________________

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have received a copy of American Medical Diagnostics Ltd (AMDX)/NeuroDiagnostic Laboratories, LLC (NDL) Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in AMDX/NDL's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the AMDX/NDL Patient Privacy Officer as indicated on your Notice.

Patient Name (Printed): ____

If Patient Representative, Name (Printed): ____

If Patient Representative, Relationship to Patient (Printed): ___________________________________

Signature: ____

Date Notice Received: ____