First Name: ____________________

Last Name: ____________________

Gender: ☐ Male ☐ Female

DOB: ____________________

Address:

Street ____________________

City ____________________ State __________ Zip __________ Phone ____________________

Cell ____________________ Other ____________________ Email ____________________

Other important people that you would like us to keep on file
(for children, please enter names and contact info of both parents)

Relationship: ☐ Mother ☐ Father ☐ Spouse ☐ Son/Daughter ☐ Other: __________

Last Name ____________________ First Name ____________________ Legal Guardian

Phone ____________________ Email ____________________ ☐ Yes ☐ No

Relationship: ☐ Mother ☐ Father ☐ Spouse ☐ Son/Daughter ☐ Other: __________

Last Name ____________________ First Name ____________________ Legal Guardian

Phone ____________________ Email ____________________ ☐ Yes ☐ No

Primary Insurance ____________________ **ID** ____________________

Policy Holder's Name ____________________ **DOB** ____________________

Referring Physician ____________________ **City** ____________________

Primary Care Physician ____________________ **City** ____________________

Pharmacy ____________________ **Phone** ____________________

Communication with Family, Friends and Healthcare Providers

I authorize the physicians and staff of Progressive Neurology to communicate and discuss my medical information with the following people. I understand that I may revoke or change this authorization at any time in writing.

____

____

____

Communication with our Staff and Physicians

Would you like to communicate with our staff and physicians by email or text messages using the numbers and email addresses listed above? ☐ Yes ☐ No

There are inherent confidentiality risks in communicating by email or text messaging. While safeguards are in place to ensure your privacy, you should not use email or text if you are concerned about any breaches of privacy that might inadvertently occur.

Aknowledgement of Receipt of Privacy Practices

I have received and reviewed the "Notice of Health Information Privacy Practices" which describes the uses and disclosures that can be made of my personal health information for treatment, payment and routine health care operations.

Initial __________

Print Name: ____________________

Signature: ____________________ **Date:** ____________________

First Name:		
Last Name:		
Gender:	☐ Male	☐ Female
DOB:		

I hereby authorize Progressive Neurology, P.C., and Hackensack Epilepsy Center, PC to furnish information concerning my illness and treatment to my insurance carriers. I authorize payment of medical benefits to the provider. I understand that I am responsible for any part of the charges that are not covered by my medical insurance.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to: Progressive Neurology, P.C., and its physicians and Hackensack Epilepsy Center, PC and its physicians. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Progressive Neurology, P.C. and its physicians and Hackensack Epilepsy Center, PC and its physicians to furnish all necessary information they may have regarding my condition under their observation or treatment, including the history obtained, x-ray, laboratory, and physical findings, diagnosis and prognosis to my insurance company(ies) and/or physicians.

MEDICAL APPEAL

I authorize to Progressive Neurology, P.C. and its physicians and Hackensack Epilepsy Center, PC and its physicians to pursue a written appeal to my insurance carrier on my behalf.

______________________________ Date: ______________

Signature (Patient or Legal Guardian)

First Name: ______________________

Last Name: ______________________

Gender: ☐ Male ☐ Female

DOB: ______________________

Authorization for release of information

I authorize ______________________ to release my medical information to Progressive Neurology, P.C. and its physicians.

Medical Information Requested:

1. ______________________

2. ______________________

3. ______________________

4. ______________________

5. ______________________

Print Name: ______________________

Signature: ______________________ **Date:** ______________

Please mail all information to:

Progressive Neurology, P.C. **260 Old Hook Rd, Suite 200** **Westwood, NJ 07675**	[OR]	**Progressive Neurology, P.C.** **381 Park St., Suite 200** **Hackensack, NJ 07601**

Or Fax to: (201)957-7316

Or E-maill to: staff@progressiveneurology.com