



BURLINGTON NEUROLOGY & SLEEP CLINIC, PLC.

Date: _____

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birthdate: _____

Marital status: Single Married Widowed Other

Pharmacy: _____ Race: _____

Patient Employer: _____ Occupation: _____

Home Phone: _____ Cell Phone: _____ Work Phone _____

Whom may we thank for referring you: _____ Family Dr: _____

Name of spouse/next of kin that we may contact: _____ Phone: _____

INSURANCE INFORMATION:

(Patient is responsible for completion of insurance information below.)

Is today's visit the result of a motor vehicle accident? Yes No: Date of injury: _____

Is today's visit the result of a personal injury? Yes No: Date of injury: _____

Is today's visit the result of a work injury? Yes No Date of Injury: _____ Claim # _____

Primary Ins. _____ Phone: _____

Primary Ins Address: _____

Policyholder's Name: _____ Employer: _____

SS#: _____ Birthdate: _____ Relationship to patient: _____

Address (if different from patient): _____

Group #: _____ Policy #: _____

Secondary Ins: _____ Phone: _____

Secondary Ins Address: _____

Policyholder's Name: _____ Employer: _____

SS#: _____ Birthdate: _____ Relationship to patient: _____

Address (if different from patient): _____

Anil Dhuna, M.D., F.A.A.S.M.

Board Certified in
Neurology, Sleep Medicine,
Neurorehabilitation and
Clinical Neurophysiology

Luanne Johnson, FNP-C

Certified Nurse Practitioner

Katie Reuter, C-NP

Certified Nurse Practitioner

I acknowledge that failure to sign this form does not release me from financial responsibility, as outlined below, for services I receive from this clinic and its physicians.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

I have seen and understand the Burlington Neurology & Sleep Clinic, PLC's Notice of Privacy Practices.

ASSIGNMENT AND RELEASE:

I, the undersigned, certify that I or my dependent assign directly to Burlington Neurology & Sleep Clinic, PLC and Dr. Dhuna, Dr. Arora, Luanne Johnson, C-NP, or Katherine Reuter, C-NP, all insurance benefits, if any, otherwise payable to me for services rendered. As a courtesy, Burlington Neurology & Sleep Clinic, PLC will bill my insurance, and it is my responsibility to ensure timely payment. Acceptance of my insurance card in no way constitutes the clinic's participation with my carrier. I understand that it is my responsibility to verify insurance coverage, eligibility and participation of this clinic and/or its doctors with my insurance carrier. I also understand that I am financial responsible for all charges whether paid or not by insurance, plus any finance charges which accrue at 18% annually on the balance not paid within 30 days of the statement date. There will be a charge of \$15.00 for all returned checks. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and communications.

CONTINUITY OF CARE:

I give my permission to Burlington Neurology & Sleep Clinic, PLC to release my records for the continuity of my care and/or to refer me for further treatment.

I, the undersigned, have read and understand the above information.

Patient (or representative) Signature

Date

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare or Medicare Advantage (any plan) benefits be made either to me or on my behalf to Anil Dhuna, M.D., Gautam Arora, M.D., Luanne Johnson, C-NP, Katherine Reuter, C-NP, Burlington, IA, for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 on the CMS-1500 form, or else on other approved claim forms or electrically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charges and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. I authorize the use of this signature on all insurance submissions, including Medicare and all of my secondary insurances.

Beneficiary Signature

Date