**Midtown Neurology MD**

**Alina Rabinovich, M.D.**

PATIENT INFORMATION

**Referred By**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Doctor**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT** Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do we have permission to leave message?\_\_\_\_\_\_\_\_\_\_\_

Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do we have permission to leave a message/Text?\_\_\_\_\_\_\_\_\_

**Person to contact in case of emergency** (Name, Relation & Phone numbers) \***REQUIRED\***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

Primary Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name, date of birth, relationship of the person who is the insured (Spouse, Father, Mother, Other):

**ASSIGNMENT OF BENEFITS, AUTHORIZATION TO RELEASE INFORMATION, and OFFICE POLICY**

I understand that I am responsible for paying all doctor’s fees in full prior to services being rendered. A claim will be submitted on my behalf and I will accept reimbursement from my insurance company in the amount dictated by my insurance plan. (Only for patients for whom office accepts assignment) I hereby irrevocably assign the insurance benefit payment, both basic and major medical, to which I am entitled, directly to the doctor rendering service. I am also responsible for all fees not paid by my insurance. A Photostat of this authorization is accepted with the same authority as the original. I hereby authorize the doctor rendering service to release any information required in the course of my examination or treatment.

I understand that this office does not participate in or work with Worker’s Comp, No Fault, Medicaid, or Medicare, and thus I am responsible for all fees associated with my visits.

I also understand and agree to pay a **$150.00** **CANCELLATION FEE** for any missed appointment. I understand that cancellations must be made at least 24 hours in advance to avoid the charge.

Insured’s Signature**\*REQUIRED\*:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person who is financially responsible if other than the patient\***REQUIRED**\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**133 EAST 58TH STREET, SUITE 401, NEW YORK, NY 10022 TEL: 212-759-5596 FAX: 212-574-3330**