DCND
Dayton Center for
Neurological Disorders

**Please review and update the information below to the best of your ability **

Patient Information

CURRENT PATIENT INFORMATION – PLEASE PRINT

Last Name:
First Name:
Middle:
Date of Birth:
Patient Email:
Address:
City: State:
Zip:
Home #:
Work #:
Cell #:
Sex:
Social Security #:
Patient Language:
Race:
Patient Ethnicity:

Are you living in an assisted /nursing facility? Yes/No
If yes, which facility?
Name:
Address:

Guarantor information (to whom statements are sent)

Last Name:
First Name:
Date of Birth:
Relationship to patient:
Phone:
Email:
Address:
City: State:
Zip:

Emergency Contact Information

Name:
Relationship:
Phone #:
Mobile Phone #:
Email:
Power of Attorney:
POA Phone #:
DNR: Yes / No (please circle)
Living Will: Yes / No (please circle)

**If you have a POA and/or answered "yes" to either DNR or Living Will, our office will need a copy of the legal document for your medical record. **

PERSONAL INDIVIDUALS WE CAN SHARE YOUR MEDICAL INFORMATION WITH:

Please initial if you do not wish to share any of your medical information: ____

Name	Relationship	Cell/Home Phone	Work Phone
Name	Relationship	Cell/Home Phone	Work Phone
Name	Relationship	Cell/Home Phone	Work Phone

POLICIES, RELEASES AND FINANCIAL RESPONSIBILITY

Payment is due at the time of service unless we are contracted with your insurance company, or you make other arrangements for payment prior to your visit.

1. All patients must complete the patient registration and health history questionnaire prior to being seen by the our providers.
2. All patients are required to provide a current copy of their insurance card and driver's license at each visit. Patients are also required to notify DCND of any changes to their insurance, demographics and whom we can share information with. DCND will not be responsible for any denials for inaccurate insurance information given or omitted by the patient.
3. I authorize the release of medical record information to the referring physician, other documented physicians, my insurance carrier(s) and the above named in accordance with HIPAA.
4. I consent to treatment necessary for the care of the above named.
5. Co-payments/unpaid balances are to be paid at the time of service, unless DCND is contracted with your insurance company. If you are not able to pay your balance in full, you must contact the DCND billing office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency.
6. Your insurance policy is a contract between you, your insurance carrier and your employer. It is the patient's responsibility to know and understand your insurance policy.
7. I authorize my insurance carrier(s) to make payments directly to DCND, if appropriate.
8. If DCND is not contracted with your insurance company and/or in network, it is your responsibility to make payment in full at the time of service. DCND will help you file your claim, but your insurance company will reimburse you directly. If you have a secondary or tertiary policy, you will need to forward a copy of your Explanation of Benefits (E.0.8.) for further billing. Patients are responsible for payment of annual deductibles and co-insurance. DCND is unable to process any third party claims (i.e.: personal injury).
9. If you do not have medical insurance, payment for any DCND service is required at the time of appointment unless prior arrangements have been made with the DCND billing office.
10. If a check is returned unpaid from the bank, a charge of $50.00 will be applied to your account.
11. If your insurance requires that you have a referral from your primary care physician, it is your responsibility to ensure that our office receives the referral prior to your appointment date. If we do not receive that referral, you will be responsible for payment of services provided or your appointment may be rescheduled.
12. Our DCND staff will try their best to pre-certify any testing that your physician might order. However, it is ultimately the patient's responsibility to check with their insurance company to see if the test needs pre-certification prior to the test being done.
13. If you are unable to make your scheduled appointment, and we are not notified at least 24 hours in advance, you may be charged a $50 cancellation fee. (Please refer to our Appointment policy for further explanation, by visiting www.dcndinc.com.) **_____Initial**
14. I understand I have certain patient rights regarding my protected health information and I authorize DCND to disclose that information to carry out treatment, payment, and health care operations. Please refer to our Notice of Privacy Practices for more information. It can be found at www.dcndinc.com. **_____Initial**

I have read and fully understand the above consent for treatment, financial responsibility, release of information and insurance authorization. I have read the above information regarding my address, insurance and personal representative and certify that it is correct and accurate. I agree to the terms outlined in this policy and understand my obligations regarding any charges incurred.

PATIENT SIGNATURE _____Date _____

REPRESENTATIVE SIGNATURE _____ Date _____