

# Kingston Neurological Associates, P.C.

365 Broadway, Kingston, NY 12401

407 B Gidney Avenue, Newburgh, NY 12550

2A Milo Street, Hudson, NY 12534

185 Green Street, Kingston, NY 12401

PATIENT'S NAME: \_\_\_\_\_ ACCOUNT# \_\_\_\_\_ DATE \_\_\_\_\_  
FIRST MIDDLE LAST

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ SEX: M  F

EMPLOYER: \_\_\_\_\_ EMPLOYER ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMERGENCY PHONE NUMBER AND NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SS#: \_\_\_\_\_ MARITAL STATUS: S  M  D  W

REFERRING PHYSICIAN'S NAME & ADDRESS: \_\_\_\_\_

FAMILY PHYSICIAN'S NAME & ADDRESS: \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_

SPOUSE'S EMPLOYERS ADDRESS: \_\_\_\_\_

SPOUSE'S WORK PHONE #: \_\_\_\_\_

IF A MINOR, NAME OF PARENT OR GUARDIAN: \_\_\_\_\_

IN CASE OF AN EMERGENCY, CALL: NAME: \_\_\_\_\_ PHONE#: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

*IF YOUR INSURANCE CARRIER REQUIRES A REFERRAL/AUTHORIZATION FROM YOUR PRIMARY PHYSICIAN, YOU MUST PROVIDE ONE, I.E., CDPHP, MVP, WELLCARE, ETC.)*

**PRIMARY INSURANCE:** \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

RELATIONSHIP TO INSURED: \_\_\_\_\_

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT): \_\_\_\_\_

SS# OF POLICY HOLDER (IF DIFFERENT FROM PATIENT): \_\_\_\_\_

DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT): \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

RELATIONSHIP TO INSURED: \_\_\_\_\_

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT): \_\_\_\_\_

SS# OF POLICY HOLDER (IF DIFFERENT FROM PATIENT): \_\_\_\_\_

DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT): \_\_\_\_\_

## INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the release of any medical and/or other information necessary to process this claim. I also request payment of insurance benefits either to myself or **KINGSTON NEUROLOGICAL ASSOCIATES, P.C.** should they elect to accept assignment, otherwise payment is due upon services.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_

## MEDICARE ONLY

I authorize any holder of medical or any other information about me to release to the social security administration and the centers for Medicare and Medicaid services or its intermediaries or carriers, or to the billing agent of this physician, any information used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_

hc07192004

TURN OVER AND FILL OUT IF YOU WERE IN A CAR ACCIDENT OR HURT AT WORK

**NO FAULT INFORMATION**

( FILL THIS OUT IF YOU WERE INJURED IN A CAR ACCIDENT.)

INSURANCE COMPANY: \_\_\_\_\_

INSURANCE COMPANY ADDRESS: \_\_\_\_\_

INSURANCE COMPANY PHONE#: \_\_\_\_\_

POLICY OR CLAIM #: \_\_\_\_\_ DATE OF ACCIDENT: \_\_\_\_\_

NAME OF INSURED (IF OTHER THAN CLAIMANT): \_\_\_\_\_

ADDRESS OF INSURED: \_\_\_\_\_

NAME OF CLAIMANT: \_\_\_\_\_

ADDRESS OF CLAIMANT: \_\_\_\_\_

DATE LAST WORKED: \_\_\_\_\_ LOCATION OF ACCIDENT: \_\_\_\_\_

HISTORY OF ACCIDENT: \_\_\_\_\_

LAWYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

I HEREBY AUTHORIZE PAYMENT OF BENEFITS UNDER THE NO-FAULT INSURANCE PLAN TO BE PAID DIRECTLY TO **KINGSTON NEUROLOGICAL ASSOCIATES, P.C.** FOR SERVICES RENDERED TO ME AS A RESULT OF AN ACCIDENT WHICH OCCURRED ON:

\_\_\_\_\_

SIGNED: \_\_\_\_\_

I HEREBY AUTHORIZE **KINGSTON NEUROLOGICAL ASSOCIATES, P.C.** TO RELEASE MEDICAL INFORMATION ON MY INJURY TO THE NO FAULT CARRIER:

\_\_\_\_\_

SIGNED: \_\_\_\_\_

I HEREBY GIVE AUTHORIZATION TO **KINGSTON NEUROLOGICAL ASSOCIATES, P.C.** TO FILE CLAIM IN MY BEHALF, IF I NEGLECT TO FILE SAME WITHIN 30 DAYS OF ACCIDENT.

\_\_\_\_\_

SIGNED: \_\_\_\_\_

**WORKMEN'S COMPENSATION INFORMATION ONLY**

WORKER'S COMPENSATION INSURANCE CARRIER: \_\_\_\_\_

ADDRESS OF CARRIER: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ TIME: \_\_\_\_\_ LOCATION: \_\_\_\_\_

POLICY OR CLAIM #: \_\_\_\_\_

HOW WERE YOU INJURED? \_\_\_\_\_

DATE LAST WORKED: \_\_\_\_\_ DID YOU SEE ANOTHER PHYSICIAN? \_\_\_\_\_ 0=NO 1=YES

IF SO, NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

IN THE EVENT I FAIL TO PROSECUTE THE CLAIM FOR WORKER'S COMPENSATION FOR THIS ILLNESS OR CONDITION OR IT IS DETERMINED BY THE WORKER'S COMPENSATION BOARD THAT THE ILLNESS OR CONDITION IS NOT A RESULT OF A COMPENSABLE WORKER'S COMPENSATION CASE OR IF I FAIL TO PROVIDE ALL THE ABOVE NEEDED INFORMATION WITHIN 48 HOURS FROM THE DATE OF SERVICE, I, \_\_\_\_\_, HEREBY AGREE TO PAY KINGSTON NEUROLOGICAL ASSOCIATES, P.C. THEIR USUAL AND CUSTOMARY FEES FOR SERVICES RENDERED TO THE ABOVE NAMED CLAIMANT IN THE ABOVE IDENTIFIED CASE.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_