SLEEP & NEUROSCIENCE ASSOCIATES

Sleep and Neuroscience Associates
55 Holly Hill Lane, Suite 210
Greenwich, CT 06830
Telephone: (203) 422-7940, Fax: (203) 422-7947

Registration Form

Date: _____ Patient: _____
Last Name First Name Middle Initial
Email: _____Home Phone: _____ Mobile Phone: _____
Responsible Party (if a minor): _____
Street Address: _____
City: _____ State: _____ Zip: _____
Sex: ☐ M ☐ F Age: _____ Date of Birth: _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
Patient Employed By: _____
Business Address: _____
Occupation: _____ Business Phone: _____
Spouse (or responsible party) Name: _____ Date of Birth:_____
Business Name and Address: _____
Occupation: _____ Business Phone: _____
Who is responsible for this account? _____ Relationship to patient: _____
Social Security #: _____ Spouse's Social Security #: _____
Do you have Medical Insurance? ☐ No ☐ Yes → If yes,
Name of Primary Insurer: _____
Contract #: _____ Group #: _____ Subscriber #: _____
Name of Secondary Insurer (if any): _____
Contract #: _____ Group #: _____ Subscriber #: _____
☐ Medicare ☐ Medicaid Claim ID #: _____
If Welfare, your number: _____ County of: _____
In case of emergency, who should be notified? _____ Phone: _____
How did you learn of our practice? _____

Assignment and Release
I, the undersigned, have insurance coverage with _____
(Name of Insurance Company)
and assign directly to Sleep and Neuroscience Associates all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges due for services that I receive, including all amounts not paid by insurance, and I will submit payment to Sleep and Neuroscience Associates. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions.

_____
Signature of Insured/Guardian Date

Medicare Authorization
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Malhotra for any services furnished to me by the 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 my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically 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 charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____
Beneficiary Signature Date