

California Neurological Specialists

Lorne S. Label, M.D., M.B.A., F.A.A.N.

A Medical Corporation, Diplomate, American Board of Psychiatry and Neurology

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PATIENT REGISTRATION

PLEASE PRINT

Patient: Age Sex: M F
Primary Language Spoken: English Spanish Other
Driver's Lic.No. Home Phone Cell Phone
Address City State Zip
Birthdate / /19 Social Security No. Marital Status: S M D W
Employer Occupation Work Phone
Address City State Zip
Referred By Reason For Visit
Date of Onset

SPOUSE INFORMATION

Spouse's Name: Social Security No.
Driver's Lic. No. Home Phone No.
Address City State Zip
Spouse's Employer Occupation
Work Phone No. Address
City State Zip

INSURANCE INFORMATION

Primary Insurance Carrier Address
Subscriber's Name Group No. Cert. No.
Secondary Ins. Carrier Group No. Cert. No.
Medicare No.

BILLING INFORMATION

Name of Person Responsible For Payment
Address City State Zip
Area Code and Phone No.

FINANCIAL & SERVICES AGREEMENT

PLEASE READ AND SIGN THE FOLLOWING:

I do hereby authorize Lorne S. Label, M.D., and his medical staff to render whatever services necessary for the care of myself or my family member. I have engaged you as my personal physician, with the understanding that you, personally, will provide the care I need whenever you are available. Considering this, I release you from any liability that may arise as a result of any care that may be provided by any physician to whom you refer me or covering you in your absence.

I hereby authorize payment directly to California Neurological Specialists (CNS) or Lorne S. Label, M.D., for any medical services. I understand that I am financially responsible for charges. CNS will bill your private insurance as a courtesy and will allow 45 days for payment. I also authorize Lorne S. Label, M.D., or CNS to furnish my insurance company with full information regarding the treatment rendered. I/ WE understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements. CNS may add one and one half percent (1.5%) per month to any balance owed. Reasonable collection charges and/or attorney fees will be added to the outstanding amount owed CNS in the event of default.

There will be a \$100.00 fee for missing a scheduled appointment or canceling with less than 24 hours notice.

Missing a scheduled EEG or EMG or canceling an EEG or EMG appointment with less than 24 hours notice or "NO SHOW" will result in a charge of \$125.00.

It is the policy of this medical practice that we will adopt, maintain and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California law.

Notice of Privacy Practices: It is the policy of this medical practice that a notice of privacy practices must be published, that this notice be provided to all subject individuals at the first patient encounter if possible, and that all uses and disclosures of protected health information be done in accord with this organization's notice of privacy practices. It is the policy of this medical practice to post the most current notice of privacy practices in our "waiting room" area, and to have copies available for distribution at our reception desk.

If this policy is not clear, please ask for clarification.

Date: / /20

SIGNATURE OF PATIENT (Parent or Guardian if patient under 18yrs.)