NISA
Neurology Institute
*of* San Antonio

## Patient Information

Name:_____
*LAST* *FIRST* *MIDDLE INITIAL*

Address:_____ City:_____ State:_____ ZIP Code:_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email:_____

Social Sec. #:_____ DOB:_____ Age:_____
*MONTH / DATE / YEAR*

Sex: ☐M ☐F Gender Identity:_____ Marital Status:_____

Primary Language:_____ Race:_____ Ethnicity: N/A Hispanic Latino

Employer:_____ Phone: (_____) _____

Contact:_____ Relation:_____ Phone: (_____) _____

Address:_____ City:_____ State:_____ ZIP Code:_____

Responsible Party *(If patient is a minor, name of guardian)*:_____

## Insurance Information

**Primary —** Name of Insurance Co.:_____ DOB:_____
*IF OTHER THAN PATIENT*

Address:_____ City:_____ State:_____ ZIP Code:_____

Name of Insured Person:_____ Social Sec. #:_____

Insurance ID #:_____ Group Name or #:_____

**Secondary —** Name of Insurance Co.:_____ DOB:_____
*IF OTHER THAN PATIENT*

Address:_____ City:_____ State:_____ ZIP Code:_____

Name of Insured Person:_____ Social Sec. #:_____

Insurance ID #:_____ Group Name or #:_____

## AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign Neurology Institute of San Antonio my medical reimbursement benefits under my insurance policies listed above. I understand that services not covered by my insurance are my financial responsibility and are due at time of service unless other arrangements have been made.

**HIPAA Notice of Privacy Practices:** I understand that Neurology Institute of San Antonio has established a Notice of Privacy Practices that provides information about how my protected health information can be used and disclosed. I consent to the use of my protected health information for the treatment, payment, and health care options. I acknowledge that I have received a copy of the Notice of Privacy Practice to read and obtain a copy to keep by requesting one from the front office.keep by requesting one from the front office.

Patient's Signature:_____ Date:_____