Dr. Arthur Itkin

Neurologic and Headache Clinic S.C.

Patient Registration Form

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred Method of Contact for Appointment Reminder Calls: ☐ Voice ☐ Text			If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work
Date of Birth:	Sex: ☐ Male ☐ Female		Family Physician:
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:			Relationship to Patient:

Additional Information and Responsible Party

Person Responsible for the bill **(ONLY IF DIFFERENT FROM PATIENT)**

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ **Yes** ☐ **No**
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic orLatino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Polish ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian ☐ Other	
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance **ID Present** ☐	**Secondary Medical Insurance** **ID Present** ☐
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I have read and agree to Neurologic Headache Clinic S.C. Financial Policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Neurologic and Headache Clinic S.C. any money to which I am entitled for medical expenses related to the services performed from time to time by Company. I authorize any holder of medical information about me to release to my Insurance Company and its agents any information needed to determine these benefits or the benefits payable for related services understand that failure to pay outstanding balances within 60 days of notification of the amount due will result in submission to an outside collection agency.
MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to Neurologic and Headache Clinic. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of the Privacy Notice of Neurologic and Headache Clinic S.C. ☐ **(Initials)**

Signature of Responsible Party: **X** _____ **Date:** _____

Printed Name of Responsible Party: **X** _____ **Date:** _____

NEUROLOGIC AND HEADACHE CLINIC S.C.

7600 W COLLEGE DRIVE
STE 5
PALOS HEIGHTS, ILLINOIS 60463

PATIENT AGREEMENTS AND AUTHORIZAITONS

(Please initial each paragraph if in agreement after reading)

Consent for Treatment. I hereby consent to the treatment provided by Neurologic and Headache Clinic S.C. and employees or designees (referred to as "the Practice"). I authorize the mental and physical health care services deemed necessary for advisable by my caregivers to address my needs. (_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATTION.

I authorize use and disclosure of my personal health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (_____)

PRIVACY POLICY. I acknowledge having received the Practice's, "Notice of Privacy Policies". My rights including the right to see and copy my record, to limit disclosure of my health information and to request an amendment to my record, are explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Practice has already made disclosure with my prior consent. (_____)

I authorize the Practice to release information about my medical condition to the following people:

Name: _____DOB:_____Relationship:_____

Name: _____DOB:_____Relationship:_____

_____ _____
Patient or Authorized Person Signature Relationship Date

_____ _____
Witness Signature Date

Patient unable to sign. Verbal consent given. Reason: _____

NEUROLOGIC AND HEADACHE CLINIC, S.C.

Medication Tracker			
NAME:		DATE:	
Medication name/strength	Purpose	Dosage/frequency/time	
Medicines allergic to:			
Any other notes / comments:			