Jasper Neurological Associates, P.C.

3850 Camp Road, Suite C

Jasper GA 30143

Patient Name: _____ Date of Birth: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer Name: _____ Work Phone: _____

Employer Address: _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widow(er)

Spouse's Name: _____ Date of Birth: _____

Spouse's Employer: _____ Work Phone: _____

Employer Address: _____

Spouse's SSN: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Referring Physician: _____ Primary Care Physician: _____

PRIMARY INSURANCE INFORMATION

Company: _____

Patient's Relationship to Insured:

☐ Self ☐ Spouse ☐ Child

SECONDARY INSURANCE INFORMATION

Company: _____

Patient's Relationship to Insured:

☐ Self ☐ Spouse ☐ Child

EMERGENCY CONTACT INFORMATION

Contact Name: _____ Contact Phone: _____

Contact's Relationship to Patient _____

AUTHORIZATION

I authorize the treatment of the above- named patient and release of any medical information to process insurance claims filed on my behalf. I authorize payment of medical benefits to Jonathan Pearlstein, M.D. for services rendered.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE ON MY ACCOUNT.

Patient Signature: _____ Date: _____

JASPER NEUROLOGICAL ASSOCIATES, P.C.
3850 CAMP ROAD, SUITE C
JASPER, GA 30143
(706)-253-1401 FAX (706)-253-1405

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____

SS#:_____

Date of Birth:_____

I hereby release and authorize: Jasper Neurological Associates, P.C.

To obtain from:_____

_____

The following type(s) of individually identifiable health information relating to me as described below:

I understand that this information may contain history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, or psychiatric disorders or tests for infection with human immunodeficiency virus (AIDS). If released, I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

The facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of health information to the extent indicated and authorized therein.

All information I hereby authorize to be obtained or released from this agency will be held strictly confidential and cannot be released without my written consent. I understand that this will remain in effect for an indefinite period of time unless I specify an expiration date here:_____.

I understand that I may refuse to sign this Authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

_____ _____

Date Signature of Patient

_____

Witness

If the patient is unable to sign, the Personal Representative must complete the following:

Reason:_____

_____ _____ _____

Date Signature of Personal Representative Relationship to Patient

F3.2B

Practice: Jasper Neurological Associates, P.C.
Address: 3850 Camp Road, Suite C, Jasper, GA 30143
Telephone: 706-253-1401

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Print Name of Patient:_____

Signature of Patient:_____

Date:_____

Patient's Date of Birth:_____

Patient's ID/Chart Number:_____

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative:_____

Describe Personal Representative Relationship_____

Signature of Personal Representative:_____

Date:_____

For Practice Use Only:

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Practice Employee Date