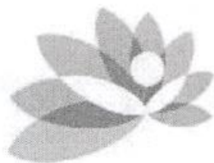

No Show/Cancellation Agreement

We understand there are times when you miss an appointment due to emergencies or obligations to work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting a much-needed appointment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for an appointment, due to a seemingly "full" schedule.

If an appointment is not cancelled at least 24 hours in advance, **you,** not your insurance company will be charged the following:

New Visit Appointment	**$200**
Follow up Appointment	**$50**
EEG/Sleep profiler/Dental Device Appointment	**$100**
Ambulatory Video-EEG Appointment	**$250**
EMG Appointment	**$200**

We appreciate your understanding and cooperation.

Patient's Name: ________________________________

Date of Birth: ____________________

Patient signature: ________________________________

Date: ____________________

-Patient Responsibility-

I understand that if my insurance plan requires a referral from my primary care physician for specialty consultation and/or service, and this it is my responsibility to ensure that Mid-Atlantic Epilepsy & Sleep Center (Dr. Pavel Klein) have that referral at the time of services. If services are rendered under circumstances when referral has reportedly been made, but was not immediately available, the referral must be received in our office within two working days of services rendered. I will be held responsible for all services rendered if referral is not received, services rendered are not specified on the referral, and date of referral does not cover date services are rendered.

I hereby affirm to the best of my knowledge, I am a duly enrolled member of ________________________________

insurance company. I understand that I am financially responsible for all services rendered if my coverage is not in effect at the time of my visit. In such case, I agree to pay Mid-Atlantic Epilepsy & Sleep Center (Dr. Pavel Klein) usual and customary charges for all services rendered. I also understand that I will be charged a $100.00 fee if I do not show up for a scheduled appointment or if I do not cancel my appointment within 48 business hours. A $200.00 fee will be charged if I do not show up for an EEG or if I do not cancel within 48 business hours.

________________________________ ________________________

Signature of Patient, Parent, Guardian or Personal Representative Date

________________________________ ________________________

Please print name of Patient, Parent, Guardian or Personal Representative Date

-Patient Acknowledgement-

I have received the NOTICE of PRIVACY PRACTICES and I have been provided an opportunity to review it.

Name________________________________ Birthdate________________________

Signature ____

Date ____

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-Additional Insurance-

Is patient covered by additional insurance? □ YES □ NO

Subscriber Name ______________________ Relation to Patient ________________ Birthdate________________

Address (if different from patient's) ____________________________________ Phone (___)________________

City______________________________ State __________________ Zip__________________________

Subscriber Employed by____ Phone (____) __________________

Name of Insurance Company ____________________________________ Soc. Sec. # ______________________

Insured ID#____________________________ Group #__________ Subscriber #___________________________

-Assignment and Release-

I certify that I, and/my dependent, has insurance coverage with____ and
Name of Insurance Company
assign directly to **Dr. Pavel Klein** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-name insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ______________________
Signature of Patient, Parent, Guardian or Personal Representative Date

____ ______________________
Please print name of Patient, Parent, Guardian or Personal Representative Date

PATIENT REGISTRATION FORM

Date__________________ **(PLEASE PRINT)**

-Patient Information-

Name____ Home Phone (_____)______________
Last Name First Name Middle Initial

Address____ Cell Phone (_____)______________

City_______________________________ State__________ Zip ____________________

Sex □ Male □ Female Age______ Birthdate ___________ Marital Status □ Married □ Widowed □ Single □ Minor

Email Address______________________________ □ Separated □ Divorced □ Partnered for ___ years

Social Security Number____________________________

Pharmacy/ Address/Phone____

Occupation_______________ Employer/School ______________ Employer/School Phone (___)______________

Referring/Primary Doctor____

In case of emergency who should be notified? ____________________________ Phone (____)______________

-Insurance Information-

□ **Check if insurance card presented at time of appointment; if so, do not complete this section**

Person responsible for account ____
Last Name First Name Middle Initial

Relation to Patient _______________ Birthdate____________________ Soc. Sec. # ________________

Address (if different from patient's) ____________________________ Phone (___)______________

City____________________________ State ________________ Zip______________________

Person responsible employed by___________________________ Occupation______________________

Business Address_________________________________ Business Phone (____) ________________

Name of Insurance Company ____

Insured ID#__________________________ Group #__________ Subscriber #______________________

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