



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 # _____



Mid-Atlantic EPILEPSY & SLEEP CENTER

-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



Mid-Atlantic EPILEPSY & SLEEP CENTER

-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 _____



MidAtlantic Epilepsy and Sleep Center, LLC

Fees for Services

Effective July 1, 2025

Appointments that are cancelled with less than 48 business hours' advanced notice or that are no showed will be subject to a fee as outlined below. Determining whether your appointment is a detailed or regular appointment is at the discretion of the practice. Patients who have 3 or more missed appointments within any given 12-month period or who have an excessive history of late cancellations, missed appointments, or a combination of the two will be subject to discharge from the practice. Please be advised that missed appointment fees will be assessed to your account and charged to your credit card on file within 7 days of the appointment. We do not generate statements for missed appointment fees.

New appointments

\$250 cancellation or rescheduling within 48 hours or no show.

Follow up visits

\$150 cancellation or rescheduling within 48 hours or no show.

EEG (1 hour to 4 hours)

\$150 cancellation or rescheduling within 48 hours or no show.

EEG (24 to 72 hours)

\$200 cancellation or rescheduling within 48 hours or no show.

Patients who have an excessive amount of late missed or combination will be subject to discharge from our practice.

FAQ

All missed appointments whether it's your first offense or third is time that your provider could have been treating another patient. Additionally, medical offices get paid only when they are seeing a patient therefore the cost of this time is passed along to the patient that either missed or late cancelled their appointment. Our billing practices are fair across the board for our entire patient population whether you are a new patient or a long-standing established patient.

We do our best to accommodate patients even when they're late but sometimes that's not feasible, your lateness may impact our ability to see other patients on time. When this occurs, you may be rescheduled to another provider which means you have now taken up two appointments in a single day. You missed one and were seen for one. Your missed appointment fee is for the appointment that you arrived late to.

Financial Responsibility

The Guarantor for the patient's policy is responsible for all co-payment, co-insurance, and deductible amounts. Additionally, the guarantor is responsible for all charges and supplies that are not covered by your insurance policy. MidAtlantic Epilepsy and Sleep, LLC does not bill service, cancellation, or no-show fees to insurance. Therefore, the Guarantor is responsible for payment of service fees and fees incurred from no show or cancellations.

Payment will be collected at the time of service for any known account balance in addition to any co-payment amount. Acceptable forms of payment include cash or credit card. We do not accept personal checks. Please be advised that all patients must keep a valid credit card on file. Failure to adhere to our financial policies will result in discharge from the practice.

Additional Service fees

Health (school/camp) forms: \$50 per form packet

EEG on disk: \$30 per test

Letters of medical necessity/clearance/advocacy: \$50 per form

Peer-to-peer communication (with another non-healthcare providers or family provider, therapist, school counselor, caretaker): \$100 per episode

Prescription refill without an office visit for > 1 year: \$50 per refill

Medical Records: \$50 per file

Patient signature: _____

Patient name (printed): _____

Date signed: _____



Credit Card Payment Authorization Form

Sign and complete this form to authorize Mid-Atlantic Epilepsy and Sleep Center, LLC (MAESC) to make a debit to your credit card listed below.

By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date.

Please complete the information below:

I _____ authorize MAESC to charge my credit card
(Full name)

account indicated below on or after _____. This payment is for fees for services and
cancellations. (date)

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

Account Type: Visa MasterCard AMEX Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV OR CVC _____

SIGNATURE _____

DATE _____

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amounts indicated in the fees for services and cancellations policy. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.