Jersey Institute of Neuroscience

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DATE:			
REFERRING PHYSICIAN'S NAME:	**PHYSICIAN'S ADDRESS:**		**PHYSICIAN'S PHONE #:**
PATIENT NAME:		**HEIGHT:**	**WEIGHT:**
MAILING ADDRESS:			
STREET ADDRESS:			
PHONE #:	**WORK #:**		**EXT:**
EMPLOYER:	**OCCUPATION:**		
BIRTHDATE:	**AGE:**	**SS#:**	**SEX:** **MALE / FEMALE**
MARITAL STATUS:	**RELIGION:**		**UNION AFFILIATION:**
CONTACT PERSON:	**PHONE #:**		

IS THIS VISIT RELATED TO A MOTOR VEHICLE ACCIDENT? **(COPY OF THE PIP APPLICATION MUST BE PROVIDED TO THIS OFFICE)**	**YES**	**NO**
IS THIS VISIT RELATED TO A WORKERS COMPENSATION CLAIM?	**YES**	**NO**
BRIEFLY DESCRIBE ACCIDENT:		

OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

OUR OFFICE IS PLEASED TO SUBMIT YOUR CLAIMS TO YOUR INSURANCE CARRIER ON YOUR BEHALF. WE WILL BE HAPPY TO ASSIST YOU IN EVERY WAY WE CAN, HOWEVER, OUR OFFICE CANNOT GUARANTEE THAT YOUR VISITS WILL BE COVERED BY YOUR INSURANCE. INSURANCE POLICIES ARE PERIODICALLY CHANGED AND IT MUST BE UNDERSTOOD THAT AN INSURANCE POLICY IS A CONTRACT BETWEEN YOU, THE INSURED, AND THE INSURANCE COMPANY, AND NOT THIS OFFICE. THEREFORE, YOU ARE FULLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES PERFORMED IN THIS OFFICE. WE ENCOURAGE YOU TO MAKE A PERSONAL VERIFICATION AND REVIEW OF YOUR POLICY COVERAGE.