Neurology, Psychiatry and Balance Therapy Center, LLC
Suite 130 Parec Plaza, 725 Skippack Pike
Blue Bell, PA 19422

Billing and Registration Form

PATIENT LAST NAME_____ FIRST NAME_____

DATE OF BIRTH ___/___/____ SOCIAL SECURITY #_____-____-_____ SEX (M / F) MARITAL STATUS_____

RACE_____ ETHNICITY_____FORMER NAME(S)_____PRIMARY LANGUAGE_____

MAILING ADDRESS_____EMAIL:_____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE # _____ CELL PHONE #_____ OTHER PHONE#_____

WHICH IS THE BEST CONTACT NUMBER? _____CAN MESSAGES BE LEFT(Y/N)

EMERGENCY CONTACT & RELATION_____ EMR. CONTACT PHONE # _____

EMPLOYER INFORMATION:

COMPANY NAME _____ WORK PHONE _____ EXT _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

BILLING INFORMATION:

NAME OF RESPONSIBLE PARTY (if other than self) _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

RELATIONSHIP _____ DATE OF BIRTH ___/___/_____ PHONE NUMBER _____

HOW DID YOU HEAR ABOUT US?
□INTERNET □DIRECTORY(specify)_____ □REFERRAL(specify)_____□OTHER_____.

"I understand and agree that regardless of my insurance coverage, I am responsible for the balance of this account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status. I understand that if I have an outstanding balance for 30 days or longer I will be charged a $50 late fee. I understand that if my account becomes delinquent and the Neurology, Psychiatry and Balance Therapy Center (NPBTC) incurs any collection charges, they will be my responsibility. I UNDERSTAND THAT IF THE BALANCE ON MY ACCOUNT IS OUTSTANDING FOR MORE THAN 84 DAYS, MY ACCOUNT WILL BE SENT TO A COLLECTION AGENCY. I understand that as a courtesy, NPBTC will attempt to verify my insurance benefits, but it is ultimately my responsibility to know my coverage. Verification of benefits is not a guarantee of payment. NPBTC strongly encourages me to reaffirm my plan particulars with my insurance company. I understand that I am responsible for payment of the co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility at each visit to the office BEFORE I see the care provider. I understand that I am responsible to present updated referrals and authorizations from my insurance carrier when required.

If the patient is a minor: **"By consenting to care at the, Neurology, Psychiatry and Balance Therapy Center I am agreeing that I will take responsibility for the payment of the medical bills. I will provide the office with all information necessary and will communicate with the office regarding any changes in responsibility.**

"I acknowledge that I have received the Notice of Health Information Practices Policy.

Patient or Guardian Signature_____ Date_____