NORAN NEUROLOGICAL CLINIC, P.A./MINNESOTA DIAGNOSTIC CENTER

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:________________________________

Patient Date of Birth: __________________________

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of the Noran Neurological Clinic, P.A./Minnesota Diagnostic Center.

______________________________________ ____________________

Signature of Patient or Personal Representative Date

____

Print Name of Patient or Personal Representative

____

Description of Personal Representative's Authority

CONTACT INFORMATION:

The contact information of the patient or personal representative who signed this form should be filled in below.

Address:

____

____

Telephone:

___________________(daytime)

___________________(evening)

The Patient or Personal Representative noted above was provided the Notice of Privacy Practices and this Acknowledgement Form and did not sign the Acknowledgement Form.

Reason for not signing:

___________________ ___________________

Name Date

____

Position

NAME: ______________________________ **DOB:**____________________

GENERAL RELEASE OF INFORMATION:

I authorize Noran Neurological Clinic on behalf of myself and/or dependents to furnish medical records, including films and billing information to my insurance company, HMO or other third-party payer as may be necessary for the payment of a bill, determination of benefits or for utilization and quality review purposes.

I further authorize the release of this information to healthcare facilities that Noran Clinic may refer me to for continuing medical care, such as clinics, labs, therapy facilities, and other providers. I understand I am financially responsible for any balance not paid by my insurance and considered the responsibility of the patient. I hereby authorize payment of medical benefits to Noran Neurological Clinic for services provided to myself and/or dependents.

If not previously revoked, this authorization will terminate in one year.

Appointment Reminders and other health-related services:

We may use and disclose medical information to contact you in regard to an appointment, possible treatment options, or other benefits or services that may be of interest to you. We may call you and, if necessary, leave messages on your answering machine. We may send you a notice if you missed your scheduled appointment asking you to contact us to reschedule.

Insurance company: ____

Signature of patient or responsible party ____________________ Date: _______

If patient unable to sign...

Reason patient unable to sign: ______________ *Relationship to patient* ______________

MEDICARE LIFETIME CONSENT/AUTHORIZATION

I request payment of authorized Medicare benefits be made either to me or on my behalf to Noran Neurological Clinic for any services furnished to me by physician/clinic/ supervisor. I authorize any holder of hospital or medical information about me and/or any information needed to determine benefits payable for related services to be released to the Health Care Financing Administration and its agents. I permit a copy of this authorization to be used in place of the original.

MEDICARE ID#: ______________ **SIGNATURE:** ______________________

NAME______________________________________ DOB: ___________________

Insurance Coverage Information

Motor Vehicle Insurance Information

Minnesota is a no-fault state. All claims go through the patient's auto insurance regardless of fault.

Motor vehicle insurance carrier: ____

Date of injury: ________________ Claim number: ___________________________

Claims address: ____

Policy number: (only needed if claim number is not available): ____________________________

Name and phone of the adjuster assigned: ____

Are you being treated for a motor vehicle related condition?…..Yes___ No ___

If yes, has your case been settled?………………..Yes___ No ___

Is your case being denied?……………………........Yes___ No ___

Do you have an attorney?…………………………Yes___ No ___

Attorney's Name: __________________________ **Attorney's Phone Number:**_______________________

☐ Check here if Noran Clinic should bill your Health Insurance should your insurance deny. List Health Insurance below.

Worker Compensation Insurance Information

Name of Employer at time of injury: ___________________________________

Workers Comp insurance carrier: ____

Date of injury: _________________ Nature of injury: _________________________________

Claim number: ________________

Claims address: ____

Name and phone of adjuster assigned to claim or contact at employer: ______________________

Are you being treated for a work related injury or condition?……..Yes___ No ___

If yes, has your case been settled?……………………Yes___ No ___

Is your case being denied?………………….............Yes___ No ___

Was a Motor Vehicle involved in the injury?………..Yes ___ No ___

Do you have an attorney?……………………………....Yes___ No ___

Attorney's Name: __________________________ **Attorney's Phone Number:** _________________________

☐ Check here if Noran Clinic should bill your Health Insurance should your insurance deny. List Health Insurance below.

Other Injury Information

Insurance carrier covering injury: ____

Date of injury: _________________ Nature of injury: _________________________________

Claim number: ________________

Claims address: ____

Do you have an attorney?……………………………....Yes___ No ___

Attorney's name: _____________________ **Attorney's phone number:** ____________________________

☐ Check here if Noran Clinic should bill your Health Insurance should your insurance deny. List Health Insurance below.

Health Insurance

Primary Insurance information-

Name of insurance: ____________________________ Insurance ph# ________________ Effective date: ______________

Policy number: ____________________________ Group or account number: _______________

Subscriber's name: ________________________ Subscribers date of birth: ________________

Secondary Insurance information-

Name of insurance: ____________________________ Insurance ph# _______________ Effective date: ______________

Policy number: _____________________________ Group or account number: _______________

Subscriber's name: ________________________ Subscribers date of birth: ________________