AMBULATORY EEG RECORDINGS, LLC
General Consent to Care and Release of Information

PATIENT INFORMATION

Last Name________________________________**First Name**____________________________**M.I.**_____

Address____**City**_______________________________

State__________**Zip Code**__________**Home Phone Number(**_______**)**_____________________________

Social Security Number________________________________**Date of Birth**_____________**Sex M F**

Work Telephone Number(_____**)**_________________________**Patient's Employer**________________

Family Physician___________________________________**Referring Physician**____________________

Emergency Contact_________________________________**Phone Number**_______________________

MINOR INFORMATION (The following must be completed if patient is a minor)

Parent/Guardian____________________________________**Phone Number**______________________

Address____

City_____________________________________**State**___________________**Zip Code**______________

HEALTH INSURANCE
(Please attach a copy of front and back of insurance card(s)).

PRIMARY INSURANCE____________________________**Address**_______________________

City________________________**State**__________**Zip Code**___________**Telephone Number**_________

Subscriber Name_________________________**ID Number**______________**Group Number**_________

CONSENT TO CARE AND RELEASE OF INFORMATION TO INSURANCE COMPANIES
I hereby consent to medical care and treatment by Ambulatory EEG Recordings, LLC. I authorize the release of any medical information or other information necessary to process my claim/charges. I also request payment of government benefits to Ambulatory EEG Recordings, LLC, for services rendered. I understand that I will be responsible for my bill not payable by my insurance, as well as all applicable co-payments, co-insurance and deductibles not paid at the time of service. I authorize Ambulatory EEG Recordings, LLC, to act as my agent in helping me obtain payment from my insurance company and any required pre-certification. I acknowledge that I have received the written Notice of Privacy Practices from Ambulatory EEG Recordings, LLC. This authorization is in effect until I revoke it.

Signature____**Date**
Patient or Guardian