

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 _____

WORKERS COMPENSATION

INSURANCE COMPANY _____ Address _____
City _____ State _____ Zip Code _____ Telephone Number _____
Employer _____ 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