

# Northwest NeuroSpecialists PLLC

5860 N La Cholla Blvd  
Tucson, AZ 85741-3537  
(520) 742-7890

## PATIENT INFORMATION

NAME (Last, First Middle)				SSN#	BIRTHDATE	SEX
LOCAL ADDRESS			CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)	
HOME PHONE	DAY PHONE		EMAIL ADDRESS		CITY, STATE ZIP	
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)		
ADDRESS				ADDRESS		
CITY, STATE ZIP				CITY, STATE ZIP		
WORK PHONE				WORK PHONE		

## RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)				SSN#	BIRTHDATE	SEX
LOCAL ADDRESS			CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)	
HOME PHONE	DAY PHONE		EMAIL ADDRESS		CITY, STATE ZIP	
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
RELATIONSHIP TO PATIENT						

## PRIMARY INSURANCE

NAME OF INSURANCE COMPANY			POLICY#			
NAME OF INSURED			GROUP#			
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$			
CITY, STATE ZIP		PHONE	DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT			EFFECTIVE DATE		EXPIRATION DATE	

## SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#			
NAME OF INSURED			GROUP#			
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$			
CITY, STATE ZIP		PHONE	DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT			EFFECTIVE DATE		EXPIRATION DATE	

**AUTHORIZATION OF INSURANCE BENEFITS:** I authorize payment of benefits to be paid to NORTHWEST NEUROSPECIALISTS, PLLC I understand that I am financially responsible for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits when coverage is subject to coordination of benefits. In the event I am delinquent in payment, I understand that there will be a \$15.00 charge posted to my account for each month I am past due. Should it be necessary to place the account with a collection agency, I understand that I will be responsible for eighteen percent (18%) simple interest on the unpaid balance. Should legal action become necessary to collect the balance due, I understand I am responsible for attorney's fees, interest and court costs.

SIGNATURE OF PATIENT/GUARDIAN

DATE