Gobinder S. Chopra, MD & Associates

BOARD CERTIFIED IN NEUROLOGY

Gobinder S. Chopra, M.D.

PLEASE PRINT CLEARLY

Patient Name: _____ Age: _____ Date of Birth: _____

Social Security#: _____ Marital Status: _____

Ethnicity _____Preferred Language _____ Race _____ Decline to specify_____

P.O. BOX's are not accepted.

Home Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Home Phone ( ) _____ Work ( ) _____ Cell ( ) _____

Email Address: _____ (**For Appointment Confirmations**)

Patient's Employer: _____ Occupation: _____

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Referring Doctor (or Primary Care Doctor): _____ **Phone:** _____

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INSURANCE INFORMATION ***(Please bring Drivers License/Photo ID and Insurance cards to window to be copied)***

Primary Insurance: _____ Phone: _____

Name of Policy Holder: _____ ID/Policy#: _____

Policy Holder Date of Birth: _____ Group #: _____ Social Security#: _____

Mailing Address for Claims: _____

Secondary Insurance: _____ Phone: _____

Name of Policy Holder: _____ ID/Policy#: _____

Policy Holder Date of Birth: _____ Group #: _____ Social Security#: _____

Mailing Address for Claims: _____

Attorney Name: _____ Phone: _____

Assignment of Benefits/Payment and Insurance Coverage/Collections Policy

I hereby authorize my insurance carrier(s) to pay: Gobinder S. Chopra, MD directly for all services. I authorize the release of **ALL** medical records or other information requested to assist in claims processing. I understand that I am fully responsible for any and all services not covered by said insurance carrier(s). I will come prepared to pay all co-payments and or deductibles etc. otherwise my appointment will be rescheduled. I understand that after 45 days my unpaid co-pay/deductible/balances etc will be forwarded to Allied Collection Agency. **If my account is forwarded to Collections:** I am fully responsible for all cost to transfer my account to **Allied Collections**.

_____ **By initialing I authorize this office to process my credit card payments by phone or mail to pay for balances or charges.**

_____ _____

Patient Signature or Authorized Person Date