**Triangle Neurology and Sleep Lab, PA**
**Laura Jozewicz, MD**
701 Exposition Place, Suite 106 Raleigh, NC 27615
Ph. 919.845.2580 Fax 919.845.2581

# New Patient Information

**Name : ______________________________________________**
Last First Middle

**Address: ____________________________City:_____________ State:___________ Zip:____**

**Home Phone: ( )______________ Work : ( )__________Cell Phone: ( )___________**

**Date of Birth: ___/____/____ Social Security # ____-_____-_____ Sex: M F**

**Marital Status: ________________ In case of Emergency: ______________________**

**Insurance Information:**

**Policy Holder:_________________________ ; His/Her DOB ____________________**

Primary Insurance:________________________ Policy Number:____________________

Secondary Insurance:________________________ Policy Number:____________________

**ASSIGNMENT OF INSURANCE BENEFITS:**
I hereby authorize direct payment to Triangle Neurology and Sleep Lab, PA all benefits, if any, otherwise payable for the services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

**CREDIT POLICY:**
For services rendered, a claim will be filed with your insurance carrier. However, all deductibles and co-payments are to be paid on the same day services are rendered. We accept cash, check, Master Card, and Visa. You will be notified when final action by your insurance has been received. If any funds are due, payment is expected with in thirty-days upon receipt of your statement.

**CANCELLATION POLICY:**
I hereby understand that if I need to cancel my appointment I must give a 24-hours notice; otherwise I will be charged a $50.00 cancellation fee for any missed office appointment or an EMG appointment.

**AUTHORIZATION FOR RELEASE OF INFORMATION:**
I hereby au authorize Triangle Neurology and Sleep Lab, PA to release any medical or incidental information that may be necessary for either medical care or in processing of claims for financial benefits. Triangle Neurology and Sleep Lab, PA may be authorized to release my protected health information to my spouse and/or other family members as needed, unless specified otherwise. I may be contacted at my home/work/cell-phone or any telephone number provided. I understand I have the right to revoke this authorization at any time.

**PATIENT PRIVACY POLICY**
I have received and/or read a copy of the Notices of Privacy Practices from Triangle Neurology and Sleep Lab, PA.

**WORKMAN'S COMPENSATION POLICY:**
We do not accept Workman's Compensation cases. By signing below, I certify that this visit is not a compensation- related visit.

I HAVE READ AND UNDERSTAND THE TERMS AND POLICIES AS STATED ABOVE.

________________________________ ___________________________
PATIENT'S SIGNATURE (or legal guardian) DATE