

**COLUMBIA UNIVERSITY HEADACHE CENTER**  
**16 E. 60th Street**  
**New York, NY 10022**

**PATIENT REGISTRATION**

**Kindly PRINT all information below.**

**PATIENT: THIS SECTION REFERS TO THE PATIENT ONLY.**

NAME		SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
ADDRESS (STREET, APT. NO., CITY, STATE, ZIP CODE)			
P.O. BOX (CITY, STATE, ZIP CODE)			
SOCIAL SECURITY NO.	MARITAL STATUS	IF MARRIED, IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOME PHONE (      )
EMPLOYER		WORK PHONE (      )	
ADDRESS (Street, City, State, Zip Code)			

**BILL TO: PLEASE COMPLETE IF PERSON RESPONSIBLE FOR BILL IS OTHER THAN ABOVE PATIENT.**

NAME		RELATIONSHIP TO PATIENT
ADDRESS (STREET, APT. NO., CITY, STATE, ZIP CODE)		
SOCIAL SECURITY NO.	HOME PHONE (      )	WORK PHONE (      )
EMPLOYER		
ADDRESS (Street, City, State, Zip Code)		
EMERGENCY CONTACT NAME:		PHONE

<b>INSURANCE INFORMATION</b>	FOR OFFICE USE ONLY BILLING CODE	<input type="checkbox"/> SP	<input type="checkbox"/> SF	<input type="checkbox"/> AS
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Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information of all carriers. Please list all numbers on your card(s). Please check your insurance policy for a waiting period before coverage or pre-existing clauses. **IF YOUR COVERAGE IS CONTINGENT ON A SECOND OPINION OR PRE-ADMISSION APPROVAL, IT IS YOUR RESPONSIBILITY TO INFORM US.**

NO COVERAGE     
  WORKER'S COMP     
  NO FAULT

1. CARRIER'S NAME		2. CARRIER'S NAME	
ADDRESS		ADDRESS	
CITY, STATE, ZIP CODE		CITY, STATE, ZIP CODE	
INSURED (Name on ID card)	DATE OF BIRTH	INSURED (Name on ID card)	DATE OF BIRTH
EFFECTIVE DATE	RELATIONSHIP TO PATIENT other <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/>	EFFECTIVE DATE	RELATIONSHIP TO PATIENT other <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/>
INSURED ID NO.		INSURED ID NO.	
GROUP NO.		GROUP NO.	
COMPANY NAME		COMPANY NAME	
PRIMARY CARE PHYSICIAN:			
ADDRESS			
CITY, STATE, ZIP CODE			
MOTHER'S FIRST NAME		FATHER'S FIRST NAME:	

I VERIFY THE ACCURACY OF THE ABOVE INFORMATION AND I AUTHORIZE THE RELEASE OF INFORMATION TO INSURER'S AS STATED ON THE REVERSE SIDE OF THIS FORM.

PATIENT OR AUTHORIZED SIGNATURE

DATE SIGNED:

**PLEASE ALSO READ AND SIGN THE FOLLOWING PAGES**

**Signature on File**  
**Medicare Part B**

Name of Beneficiary: \_\_\_\_\_

Health Insurance Claim Number \_\_\_\_\_

I request that payment of authorized health insurance benefits, including Medicare and Medigap, be made either to me or on my behalf to Dr. \_\_\_\_\_ for services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Signature on File**  
**Commercial Insurance**

I hereby authorize direct payment of surgical/medical benefits to Dr. \_\_\_\_\_, for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize Dr. \_\_\_\_\_ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OUR FINANCIAL POLICY**

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, or your financial responsibility.

**PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. A PHOTOCOPY OF YOUR INSURANCE CARD(S) WILL BE MADE FOR YOUR FILE.**

• **CO-PAYMENTS** - By law we **MUST** collect your carrier designated copay at the time of service. Please be prepared to pay that copay at each visit.

• **NON CO-PAY PLANS** - If your plan does not require a copay and we participate, we will accept the designated fee. You are responsible for any deductible and balance your plan indicates on their explanation of benefits.

• **REFERRALS** - If your plan requires a referral from your primary care physician it is **YOUR** responsibility to obtain it prior to and have it with you at the time of your visit. If you do not have your referral, **YOU WILL BE REQUIRED TO SIGN A FINANCIAL WAIVER**. It is then your responsibility to provide us with the referral as soon as possible. **IF A REFERRAL CANNOT BE OBTAINED FROM YOUR PRIMARY CARE PHYSICIAN YOU WILL BE RESPONSIBLE FOR THE CHARGES FOR THE SERVICES PROVIDED.**

• **SELF PAY PATIENTS** - Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance sent to your carrier, who will reimburse you directly.

• **MEDICARE** - We submit all Medicare claims, patients are responsible for the deductible and the 20% co-insurance. Secondary insurance may reimburse for your Medigap deductible and co-insurance.

• **USUAL AND CUSTOMARY** - Is a term developed by the insurance carrier to reflect average charges from specific physicians in designated geographic localities. The usual and customary amount noted on the explanation of benefits does not accurately reflect individual physician charges. Therefore the usual and customary amount does not supersede the physician's charge.

You are responsible for the timely payment of your account.

**WE ACCEPT CASH, CHECKS, MASTERCARD, AMERICAN EXPRESS OR VISA.**

THANK YOU for taking the time to review our policies. Please feel free to ask questions or share with us special concerns.

RESPONSIBLE PARTY SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_