



ROCKLAND NEUROLOGICAL ASSOCIATES

2 Crosfield ave. west nyack, n.y. 10994

845.353.4344

F 845.353.2661

web site: www.rocklandneurological.com

EARL L. ZEITLIN M.D.

MARC D. LONDON M.D.

DAVID T. OBER M.D.

MARIANNA GOLDEN M.D.

MELISSA M. YU M.D.

JOHN A. FERRO M.D.

LAURA A. GARCIA A.C.NP

DENISE SCHULTZ FNP

DATE _____

NAME _____ SEX _____ MARITAL STATUS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE # (____) _____ AGE _____ DATE OF BIRTH _____

S.S. # _____ REFERRING DOCTOR _____

PRIMARY DOCTOR _____

PATIENT'S EMPLOYER _____ BUSINESS PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE, PARENT OR GUARDIAN'S NAME _____

PHONE # _____ DATE OF BIRTH OR SPOUSE, PARENT OR GUARDIAN _____

PRIMARY INSURANCE _____

NAME OF SUBSCRIBER _____ RELATIONSHIP _____ DOB _____

ID # _____ GROUP # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE # _____

CO-PAY AMOUNT \$ _____ IS A REFERRAL NEEDED FOR SPECIALIST? (YES OR NO) _____

SECONDARY INSURANCE _____

NAME OF SUBSCRIBER _____ RELATIONSHIP _____ DOB _____

ID # _____ GROUP # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE # _____

CO-PAY AMOUNT \$ _____ IS A REFERRAL NEEDED FOR SPECIALIST? (YES OR NO) _____

Assignment of Benefits

I hereby authorize direct payment of medical benefits to RNA for services rendered in person or under supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to Release Information

I hereby authorize RNA to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Medicare - Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

SIGNATURE _____ DATE _____

***** PLEASE READ AND SIGN THE BACK OF THIS PAGE *****