Sarasota Neurology, P.A.
V. Daniel Kassicieh, D.O., FAAN, FACN
3501 Cattlemen Road, Suite B
Sarasota, FL 34232
(941) 955-5858, (941) 955-0044 (fax)

REFERRED BY: ______________________________ **PHONE**:________________________ **DATE**:___________________

Last Name____________________________________ **First Name**__________________________ Middle________________

Address_________________________________ Apt.#_______ City____________________ State______ Zip_______________

Home Phone:______________________ **Cell Phone:**_____________________ **Out of State Phone**:___________________

DATE OF BIRTH:__________________ **GENDER**: M F **MARITAL STATUS**: SINGLE MARRIED DIVORCED WIDOWED

Out of Town Address_________________________________ City____________________ State________ Zip_______________

Patient Employer____ Work Phone:________________________ Ext. #________

Soc. Sec No.________________________ Person Responsible for Bill_______________________ **Phone:**__________________

Primary Insurance____ Policy #____________________________

Address____ Group#____________________________

City_______________________________ State______ Zip________________ **Phone:**__________________________________

Subscriber________________________________ Date of Birth_________________ Relationship_________________________

Name of person(s) to release Medical Information to:_________________________ Relationship____________________

Address________________________________ State______ Zip_________ **Phone:**_____________________________________

Name of Emergency Contact Person:______________________________ **Phone:**__________________________________

Relationship_______________________ Address____________________________________ State________ Zip_____________

LIFETIME AUTHORIZATION AND RELEASE

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to Sarasota Neurology, P.A. or V. Daniel Kassicieh, D.O. or authorize such physician or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurance.

I hereby authorize Sarasota Neurology, P.A. to release to my representative, my attorney, my physicians and my insurance company any information, including diagnosis and records for any treatment or examination rendered to me during the period of such medical or surgical care.

I also authorize payment be issued directly to Sarasota Neurology, P.A., the amount due me in my pending claim for services of medical and/or surgical treatment.

I shall accept legal responsibility for the total fees due Sarasota Neurology, P.A. and I understand that interest will be added to my bill at the rate of 1% per month for any amount over 90 days and that if collection activity becomes necessary, that I am responsible for the outstanding balance plus interest, attorney fees, collection agency fees and any and all court costs or collection costs.

I shall accept legal responsibility for the total fees due Sarasota Neurology, P.A. that any unpaid balance will be paid by me except for managed care insured, even if the insurance allowance for services is less that the fees charged.

I agree that these provisions will remain in effect until I provide written revocation to V. Daniel Kassicieh, D.O.

Signature: ____ **Date**: ____________________________