PATIENT INFORMATION SHEET

Patient Name: _____ EEG#_____

Date of Birth: _____ S.S#:_____ Sex: MALE/FEMALE

Address:_____City:_____Zip:_____

Home Phone: _____ Work Phone: _____ Cell: _____

Mom's Name: _____ Date of Birth: _____ S.S#: _____

Dad's Name: _____ Date of Birth: _____ S.S#: _____

Emergency Contact_____ Phone: _____ Relationship: _____

Name of Doctor who referred you to see Dr. Osterman: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance_____ ID#_____ Group#_____

Address: _____Phone:_____

Insured's Name_____ Insured's Date of Birth: _____

Insured's Employer_____ Phone: _____

Employer's Address_____

Secondary Insurance_____ID#_____Group#_____

Other persons authorized to bring child in for treatment:
Name: _____ Relationship: _____

Name: _____ Relationship: _____

CONSENT FOR TREATMENT

I authorize the examination and treatment by Dr. Osterman. I understand that should more specialized tests and procedures be required, these will be explained by Dr. Osterman or his designee and my consent will be obtained. I have been notified of the Protected Health Information (PHI) policy.

ASSIGNMENT OF BENEFITS

I understand that I am personally responsible, or cause the responsible party to be liable, for all or any part of my bills for treatment and/or consultation by Dr. Osterman. If it becomes necessary to involve a collection agency to satisfy your balance, you will be held responsible for the fees incurred in the collection of this balance. Returned checks are subjected to a $25.00 service charge and all future payments are to be paid by cash or credit card until the balance and service charge are satisfied.

MISSED APPOINTMENTS

I understand that my child's care may be terminated after a second missed appointment or cancellation without at least 24hr notice. **Cancellations or NO SHOWS without 24-hour prior notice will be charged a *$35.00* missed appointment fee, not billable to your insurance company and/or Medicaid.**

_____ _____

Parent/Guardian Signature Date