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

Last Name: _____First Name: _____Middle: _____

Date of Birth: _____ Gender: M F Marital Status: S M D W Social Security #: _____

Mailing Address: _____Apt.#: _____City: _____State: _____

Zip: _____ Physical Address: _____City:_____State: _____

Home Phone: _____Cell: _____Work: _____Ext: _____

We utilize an automated system for appointment reminder calls, which number would you prefer to be contacted at?

Home or Cell? May we leave a message? Y/N Email Address: _____ Can we send

information to you via email? Y/N Primary Care Provider: _____ Phone: _____

Do you have an Out of Town Address? If yes, Mailing Address: _____

City: _____ State: _____ Zip: _____ Out of Town Phone: _____

Person Responsible for Bill/Subscriber:_____Relationship:_____Date of Birth: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Name of person(s) to release information to (appointment or medical information): _____

Relationship: _____ Phone: _____Other person: _____

Relationship: _____ Phone:_____

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 Daniel Kassicieh, D.O. or authorize such physician or organization to submit a claim to Medicare for payment for services of medical and/or surgical treatment. This authorization also applies to all other insurance carriers. I authorize payment be issued directly to Sarasota Neurology, P.A.

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. This information will be used for the purpose of claim payment, appeal process if claim is denied and periodic chart audits from insurance carriers for quality assurance.

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

Signature: _____Date: _____