Clifford Segil D.O.

Neurology

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DATE	NAME (LAST, FIRST, M.I.)		DATE OF BIRTH
REFERRED BY:			
ADDRESS		CITY	STATE ZIP CODE
HOME TELEPHONE # ( )	WORK TELEPHONE # ( )	CELL TELEPHONE # ( )	E-MAIL ADDRESS
SOCIAL SECURITY # - -	DRIVER'S LICENSE # (IF NOT CA, LIST STATE)		MARITAL STATUS SINGLE_____ MARRIED_____ DIVORCED_____ WIDOWED ____
SPOUSE'S NAME		CELL TELEPHONE # ( )	WORK TELEPHONE # ( )
EMERGENCY CONTACT		RELATIONSHIP	TELEPHONE #

EMPLOYER INFORMATION

OCCUPATION	YOUR EMPLOYER		
EMPLOYER ADDRESS		CITY	STATE ZIP CODE

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE COPY OF INSURANCE CARD & DRIVER'S LICENSE

INSURANCE COMPANY NAME			
PRIMARY SUBSCRIBER	MEMBER #		GROUP NAME
GROUP NUMBER	SUBSCRIBER'S DATE OF BIRTH (MM/DD/YY) / /		SUBSCRIBER'S SOCIAL SECURITY # - -

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME			
PRIMARY SUBSCRIBER	MEMBER #		GROUP NAME OR NUMBER
GROUP NUMBER	SUBSCRIBER'S DATE OF BIRTH (MM/DD/YY) / /		SUBSCRIBER'S SOCIAL SECURITY # - -

I hereby authorize Dr. Clifford Segil to release any and all medical (including dental) information to the above-named insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign to Dr. Clifford Segil all money to which I am entitled for medical and /or surgical expense relative to the service rendered by him, but not to exceed my indebtedness to said physician and /or surgeon. It is understood that any money received from the above named insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and /or Court cost and reasonable legal fees should this be required.

A $50 fee will be charged for any appointment cancelled less than 24 hours prior to scheduled appointment.

_____ _____

DATE **SIGNED (Insured or Guarantor)**