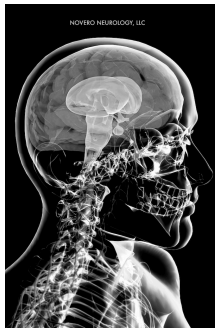

NOVERO NEUROLOGY, LLC

3150 N. Tenaya Way, Suite 555
Las Vegas, Nevada 89128
Phone: (702) 685- 8392
Fax: (702) 475-5219

PATIENT INFORMATION

NAME (Last, First, Middle) _____

SSN _____BIRTHDATE _____SEX_____

ADDRESS (Street, City, State, Zip) _____

HOME PHONE_____CELLPHONE_____WORKPHONE_____

PRIMARY CARE PHYSICIAN_____REFERRING PHYSICIAN_____

PRIMARY EMPLOYER_____

ADDRESS (Street, City, State, Zip) _____

SECONDARY EMPLOYER_____

ADDRESS (Street, City, State, Zip) _____

RESPONSIBLE PARTY INFORMATION

NAME (Last, First, Middle) _____

SSN _____BIRTHDATE _____SEX_____

ADDRESS (Street, City, State, Zip) _____

HOME PHONE_____CELLPHONE_____WORKPHONE_____

RELATIONSHIP TO PATIENT_____

SIGNATURE OF PATIENT / GUARDIAN_____DATE_____

NOVERO NEUROLOGY, LLC

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY_____POLICY #_____

NAME OF INSURED _____GROUP #_____

RELATIONSHIP TO PATIENT_____DATE OF BIRTH_____

SECONDARY INSURANCE (If Applicable)

NAME OF INSURANCE COMPANY_____POLICY #_____

NAME OF INSURED _____GROUP #_____

RELATIONSHIP TO PATIENT_____DATE OF BIRTH: _____

SIGNATURE OF PATIENT / GUARDIAN_____DATE_____

NOVERO NEUROLOGY, LLC

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND / OR CAREGIVERS

I _____Date of Birth_____

hereby authorize Novero Neurology LLC to disclose my protected health information to the following :

Name_____ Relationship_____Phone number_____

Name_____ Relationship_____Phone number_____

Name_____ Relationship_____Phone number_____

I understand that I have the right to revoke this authorization at any time however; in the event that I do, it does not apply to the information that has already been released.

I can refuse to sign the authorization and I need not to sign this form in order to be assured of treatment.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and Federal Confidentiality Rules may not protect the information.

Any questions that I may have regarding the disclosure of my health information, I can request for my Notice of Privacy in the office.

SIGNATURE OF PATIENT / GUARDIAN_____DATE_____

NOVERO NEUROLOGY, LLC

ASSIGNMENT OF BENEFITS FORM

Patient name _____Date of Birth_____

I hereby authorize Novero Neurology, LLC to submit claims on my behalf to the insurance company that I have provided in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure claim is paid in full.

I hereby instruct and direct (primary) _____
(Secondary)_____
Insurance company to pay directly to Novero Neurology, LLC at 3150 Tenaya Way, Suite 150, Las Vegas, Nevada 89128.

If my current policy prohibits direct payment to the provider of service, I hereby instruct and direct (insurance company)_____
to write a check for me and mail it to Novero Neurology, LLC at 3150 Tenaya Way, Suite 150, Las Vegas, Nevada 89128 for the professional or medical expense benefits allowable.

I authorize the release of information pertinent to my case to any insurance company, adjuster or attorney involved in my case.

I fully agree and understand that I am responsible for full payments of my medical debt if my insurance company refuses to pay 100% of my benefits.

A photocopy of this assignment shall be considered as effective and valid as the original.

SIGNATURE OF PATIENT / GUARDIAN_____DATE_____

NOVERO NEUROLOGY, LLC

Pharmacy name_____

Pharmacy Address_____

Pharmacy Number_____

MEDICATION ALLERGIES: _____

MEDICATION LIST:

DRUG NAME	DOSAGE	HOW OFTEN	STARTED	STOPPED	REASON FOR TAKING

NOVERO NEUROLOGY, LLC

FINANCIAL POLICY

Novero Neurology, LLC believes that a good doctor and patient relationship is based upon understanding through open communication. The following is to provide you with detailed information about our policies to allow better understanding of your financial responsibilities for our professional services.

- All co-payments and deductibles are due at the time of service.
- We will submit an insurance claim on your behalf as a courtesy however; it is your responsibility to follow up with your insurance company in the event that your claim is unpaid. If there are any information changes you must notify us immediately.
- Your insurance company does not cover all services that are provided. It is your responsibility to know the limitations and exclusions of your benefits. Fees for non-covered services are due at the time services are rendered.
- If you receive payment from the insurance company for service provided by our practice, you have 10 days to forward it to our office. Failure to do this, we shall refer the matter to a collection agency or claims court.
- Returned checks are subject to a $25.00 fee in addition to any fees imposed.
- You may be charged $25.00 for any missed or cancelled appointments without 24-hour prior notice.
- You must allow us to make a photocopy of the front and back of each medical plan ID card/s and valid driver's license or any valid picture ID card. You must give us yours and the policyholder's date of birth and social security number for each plan. We only use SSN for filing your medical claims and collection payment due.

We understand that temporary hardships may affect your timely payment of your balances so we highly encourage that you communicate with us so we can assist you in the management of your account.

I have read, understood and agreed to this Financial Policy.

Patient or responsible party _____Date (MM/DD/YEAR)_____

Patient's signature _____Date (MM/DD/YEAR)_____