Michele D. Kleiman, MD
Phone: 860-635-3600
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Children's Neurology Services LLC

147 Saybrook Road
Middletown, CT 06457

Acct#: ________

PATIENT INFORMATION FORM

Bring this form with you, your insurance card and child to office visit along with any useful information, EEG, MRI, IEP, PPT, Note from teachers explaining how your child is in the school setting, videos showing actions, etc.

Patient Name: ____
(Last) (First) (Middle)

Address: ____

____
(City) (State) (Zip)

Date of Birth: ____________ Age: _____ Sex: [ ] Male [ ] Female Social Security#: ____________

Phone:
Home: ( ) ____________ Work: ( ) ____________ Cell: ( ) ____________

Pediatrician: ____________________ City: ____________ Phone # ____________

PARENT INFORMATION

Name: ______________________________ Social Security#: ____________
(Last) (First) (Middle)

Employer: ____________________ Work#: ( ) ____________

Primary Insurance: ____________ Insurer's Name: ____________ ID#: ____________

Secondary Insurance: ____________ Insurer's Name: ____________ ID#: ____________

Does Your Insurance require a referral for specialist? [ ] Yes [ ] No
If yes, you are responsible to get referral from your pediatrician otherwise you will be held responsible for the bill at the time of service.

Medical Authorization – Assignment of Benefits

I hereby authorize the release of any medical information necessary to process claims for any and all professional services rendered by Children's Neurology Services, LLC and understand co-pays, deductibles, and denied services will be my responsibility upon receiving the bill. These are expected to be paid in full. Our office does not accept budget plans.

Please Read Before Signing

I hereby understand that I will be billed a $125.00 fee for any missed appointments.
A fee of $400.00 applies for New Patient appointments.

*Signed: ______________________________ *Date: ____________

****** IMPORTANT ANY INSURANCE WITH DEDUCTIBLES ****.**
******$150.00 WILL BE DUE ON THE DAY OF NEW PATIENT VISIT. ******