(Accredited by American Academy of Sleep Medicine)
M Shaffi Kanjwal, MD, Director, Clinical Neurophysiology Services, PC
Board Certified, Sleep Medicine
Beaumont Physician Office Building, 44344 Dequindre Rd #360, Sterling Hts, MI 48314
Tel: (586) 254-0707; Fax: (586) 254-7207
website: www.SleepAndAttentionDisorders.com

PLEASE COMPLETE REGISTRATION INFORMATION BELOW. PLEASE PRINT WITH BLACK INK.

Name (Last):_____(First):_____(MI): _____Social Security #:_____

Address:_____City:_____State:_____Zip:_____

Home Phone No:_____Work Phone:_____Cell Phone:_____

Sex: Male (_____)/ Female (_____) Birthdate:_____email:_____

Marital Status: Single (_____)/ Married (_____)/ Divorced (_____)/ Widowed (_____)/ Separated (____)

License No & state:_____

Race: Amer Indian-Alaska native(_____)/Asian(_____)/Black(_____)/NativeHawaiian- Pac Islander(_____)/

White(_____) Ethnicity: Hispanic- Latino: Yes(_____)/No(_____) Preferred Language:_____

How did you find out about us?_____

Employer:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

Insurance: _____ID #:_____Group #:_____

Subscriber:_____Relationship with patient:_____

Subscriber's Employer:_____Employer Ph:_____

Preferred Pharmacy:_____City:_____State:_____Phone:_____

Mail order Pharmacy:_____City:_____State:_____Phone:_____

Name of spouse (or parent of minor/guardian signing below):_____Relationship:_____

License No:_____Birthdate:_____Sex: Male (_____)/ Female (_____)

Spouse or Guardian's Employer:_____Employer Ph:_____

Referring Physician:_____Ph:_____Fax:_____

Primary Care Physician:_____Phone:_____Fax:_____

Additional Physician:_____Phone:_____Fax:_____

Other person to share med info with:_____Relationship:_____Phone:_____

Other person to share financial info with:_____Relationship:_____Phone:_____

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FINANCIAL AGREEMENT AND AUTHORIZATION/ CONSENT

I request Clinical Neurophysiology Services, P.C. (CNS) to evaluate and treat me, and consent to the use and disclosure of my health information to carry out treatment, payment, research and health care operations of CNS, including disclosure to and by others providing health care to me. I consent to review of my medical records to gather data for quality improvement or research purposes, as long as I am not identified. I consent to being contacted using any of the contact information provided. I may withdraw my consent at any time by writing to this office.

I understand that payment for services is due at the time of service, unless office staff has approved payment arrangements in advance. This will include **deductibles** (amounts I pay for health care services before health insurance begins to pay), **coinsurance** (my share of the costs of a health care service, usually figured as a percentage of the total for the service), and **co-payments** (fixed amount I pay for a health care service, may vary by type of service), and non-covered services. I may pay by cash, checks, or credit card. I authorize the office to check my credit rating if I have an unpaid balance or request a payment plan. Services cannot continue without payment for previous services. I understand that returned checks and balances older than 30 days are an expensive problem. The office may charge a $10 per month statement fee for such accounts. The office may also charge additional collection and attorney fees and interest at 1% per month in such cases. The office also may charge additional fees for broken appointments and appointments cancelled without 24 hours' notice ($25 for office visits and $100 for testing appointments). I realize that:

1. My insurance is a contract between me, my employer and the insurance company. The doctor's office is not party to that contract unless otherwise specified in writing.
2. Not all services are a covered benefit in all contracts. Some companies select services they will not cover.
3. My insurance company or health plan may determine (based on its own arbitrary guidelines) that a procedure/test is not "medically necessary" and may not pay for the service.
4. If my insurance company requires pre-certification, authorization, or a referral in order to pay for services provided, it is my responsibility to arrange such pre-certification, authorization or referral before or at the time of the service. If I do not, I understand that I will be financially liable for payment for such service(s), notwithstanding any statement by my insurance company that I am not liable for payment.
5. Insurance companies make it very difficult, if not impossible, to get accurate deductible, copayment, coinsurance, and coverage information, and do not guarantee that they will honor the information they provide. This office will do its best to give me as much advance information about charges and my costs as it can. However, it cannot guarantee the accuracy of this information or that the insurance company will pay what it initially indicates.

I understand that I will have to pay any balance of the professional charge over the insurance payment. **It is unlawful to routinely waive co-payments, deductibles, coinsurances or other patient responsibility payments** (Fed Reg 67:236, 72896, 2002). Regardless of my insurance status, I am finally responsible for the balance on my account for any professional services rendered. By allowing a procedure/test, I clearly acknowledge that the provider explained the procedure/test; the need to perform it; and the chance that my insurance or health plan may not pay for this service because it will/may determine it to be a non-covered benefit or to be "medically unnecessary". If my insurance determines the service(s) to be a non-covered benefit or to be "medically unnecessary", I understand that I will be financially liable for payment for such service(s).

I request that authorized insurance (including Medicare/ Medicaid) benefits be paid on my behalf to the provider for any services furnished me by this provider and its agents. I have received a copy of this office's Notice of Privacy Practices. If the patient is a minor or has a guardian, I am the patient's parent/guardian and agree that I am financially responsible for payment of service(s) to patient.

Patient Signature: _____ Date: _____

Signature of parent (of minor) or guardian:_____ Date: _____

Witness Signature: _____ Date: _____