Austin Sleep Disorders Center
&
Austin Neurological Institute

Today's Date:	Social Security Number:
Last Name: First: MI:	Sex: M F Ethnicity:
Address:	Birth Date: Age:
City/Town: State: Zip Code:	Home Phone: Cell Phone: Work Phone:
Occupation or Student Status:	Referring Physician Name: Primary Care Physician Name:

Emergency contact: _____ ***Relationship:*** _____ ***Phone:*** _____

PRIMARY INSURANCE:

Carrier: _____

Cardholder's Name: _____

Relationship to Patient: _____

Cardholder's Birth Date: _____

Cardholder's SSN# _____

ID# _____

Effective Date: _____

SECONDARY INSURANCE:

Carrier: _____

Cardholder's Name: _____

Relationship to Patient: _____

Cardholder's Birth Date: _____

Cardholder's SSN# _____

ID# _____

Effective Date: _____

Office visits co-pays or deductibles are payable on the day you are seen. Please remember you are responsible for all fees, regardless of insurance coverage. All HMO's IPA's and EPO's require prior authorization for each office visit. This is your responsibility. If we do not receive the authorization, payment is due at the time of service. I also acknowledge and accept the office policies of Dr. Soe Aung, M.D. | Michael Hummer, M.D. | Iris Wingrove, M.D. | Pamela Howard, M.D. Carol LaRue, D.M.D.

Signature of Patient or Responsible Party: _____ ***Date:*** _____

My signature below confirms the following:

a. Information listed in my medical and financial file today is accurate and true to the best of my knowledge.
b. I also confirm my insurance listed is effective for today's services.
c. I understand to assure accurate records, I will update any of this information when necessary.
d. I authorize the release of medical or other information necessary to process this claim.
e. I authorize payment of medical benefits to Soe Aung, M.D., P.A.| Michael Hummer,M.D. | Iris Wingrove, M.D. | Pamela Howard, M.D.
f. I have read Privacy Policies of this office
g. I have read and agree to Financial Policy of this office.
h. I have read and agree to the Prescription Policy of this office.
i. I have read and agree to the Cancellation Policy of this office.

Patient/Parent Signature _____ ***Date*** _____