Patient Information/Intake

First Name: _____ Middle Name: _____ Last Name: _____

Address:_____ _____ Apt/Unit:_____

City:_____ State:_____ Zip:_____

Date of Birth: ____/____/_____ Gender: _____ Last 4 of Social Security #: ____ ____ ____ ____

Home Phone #: _____ Cell #: _____E-Mail: _____

Emergency Contact: _____ Phone#:_____ Relationship:_____

Primary Doctor:_____ Phone #: _____

Referring Doctor:_____ Phone #: _____

Do you live in a Skilled Nursing or Assisted Living Facility, or Rehab Center? __Y __N name/phone:_____

Consent for Treatment

The patient/legal guardian authorizes The Greater Buffalo Centers for Dizziness Balance staff to administer appropriate testing and/ortreatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Consent to Release Medical Information

I authorize Greater Buffalo Centers For Dizziness and Balance to release any information acquired in connection with my diagnostic/treatment services including, but not limited to, diagnosis & clinical records, to myself, my insurance(s), physician(s), and _____

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to the Greater Buffalo Centers for Dizziness and Balance.

Primary Insurance Name _____ ID # _____ Group # _____

Primary Insurance Card Holder Name _____ Primary Card Holder Date of Birth ___ / ___ / ___

Secondary Insurance Name _____ ID # _____ Group # _____

Initial here

Guarantee of Payment: I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

Cancellation/No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when a patient does not call to cancel an appointment, he/she is preventing another patient from getting much needed assistance. Out of this necessity, if an appointment is not cancelled by 4 PM the day preceding the scheduled appointment, a fifty dollar ($50.00) fee will be charged; this will not be covered by your insurance company. Thank you for understanding

I hereby certify that I understand these rights as set forth

I acknowledge that I have been informed of GREATER BUFFALO CENTERS FOR DIZZINESS AND BALANCE's Privacy Practices as required by the Health Insurance Portability andAccountability Act (HIPAA). I have the option to request full details regarding the privacy of my information.

A current copy of GREATER BUFFALO CENTERS FOR DIZZINESS AND BALANCE Privacy Practices is available to you upon request.

Client/Responsible Party Signature: _____Date:_____

Legal Representation (If applicable): Name:_____ Signature:_____