Nasser Razack, MD, PA - Neurointerventional Associates, PA
5338 1st Avenue North, St. Petersburg, FL 33711
Phone: 727-289-7139 Fax: 727-289-7140

Date:______________________ Acct #:______________________

Name (Mr., Ms., Mrs.):______________________

Address:______________________

City:______________ State:________ Zip:________ Email:____________

Phone (Home):______________ (Cell):______________

SSN:____________ Age:______ DOB:___/___/_____
Married:_____ Single:_____ Other:_____

Occupation:______________________

Employer:______________________
Employer Address/Phone:______________________

Spouse/Parent Name:______________________
Spouse/Parent SSN:____________ Spouse/Parent DOB:___/___/_____
Spouse/Parent Employer:______________________

Name of Insured on policy:______________________

Name of Insurance Company (Primary):______________________
Name of Insurance Company (Secondary):______________________
*****(WE WILL NEED COPIES OF INSURANCE CARD(S) AND DRIVERS' LICENSE)*****

Major Complaint:______________________

Nearest Relative/Friend who may be called in case of emergency:______________________
Relationship:______________ Phone:______________

Primary Care Physician:______________ Requesting Physician:______________

<u>It is usual and customary to pay for services as rendered unless otherwise arranged.</u>

*I do hereby authorize Nasser Razack, MD to furnish my insurance company with a full report of physical examination, diagnosis, treatment, prognosis, and etc. of myself in regard to my injury, if requested by them.
*I hereby authorize and direct payment directly to said Doctor such sums as may be due on owing him for services rendered to me. <u>I understand I am directly and fully responsible to said Doctor for ALL medical bills submitted by him for services rendered to me.</u> This agreement is made solely for said Doctor's additional protection and in consideration of his awaiting payment.
*I have read and agree to be bound by the terms of this assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting said Doctor's interest, he will not await payment but may declare the entire balance due and payable – these assigned proceeds shall not exceed amounts due and payable to said Doctor for services rendered.

Patient's Signature:______________________ **Date:**____________

FOR OFFICE USE ONLY:
Procedure Code:______________________

Desription:______________________

Diagnosis Code:______________________