Julia Samton, MD
Fellow, American Board of Neurology and Psychiatry

Confidential

Date:_____

Patient Name:_____ SSN:_____-_____-_____
Last First M.I.

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:(____)_____-_____ Work Phone:(____)_____-_____ Ext:_____

Gender: [ ] Male [ ] Female Date of Birth:_____-_____-_____ Age:_____

Email_____

Marital Status: [ ] Married [ ] Single [ ] Divorced
[ ] Separated [ ] Widowed [ ] NA (children)

Employment Status: [ ] employed [ ] student
[ ] employed/student [ ] unemployed

Employer: _____

Insurance Company:_____

Grp#:_____ID#_____

Telephone # for providers/precertification on back of card: _____

Email:_____

Referral Source: (include name, address, and phone number)

_____

Primary Care Physician: _____ Phone:_____

<u>In Case of Emergency, Contact:</u>

Name:_____ Relationship:_____

Phone:_____

<u>If patient is minor:</u>

	[ ] Mother (or Guardian)	[ ] Father
Name:	_____	_____
Address:	_____	_____
	_____	_____
	_____	_____
(H) Phone:	_____	_____
(W) Phone:	_____	_____

Billing Information:

Unless stated otherwise, please provide payment at the time of service. You will be provided with a receipt via email, unless specified below. To assure expedient response, be sure to notify your insurance company that you will be submitting an out of network for the date and services rendered. Be sure to indicate clearly that reimbursement should be sent directly to you, the “patient”, and not to Julia Samton, MD, the “provider”.

Your insurance may occasionally contact me for precertification for a procedure, medication, or to insure payment to for my services. By signing below, you permit me to communicate to your health insurance company on your behalf and argue for the highest possible level of reimbursement.

Signature:
_____Print:_____

Date_____

If you wish to submit payment via credit card, please indicate below.

Credit card type:

American Express: _____

Exp. Date: _____ Security code:_____

Visa: _____

Exp. Date: _____ Security code:_____

Mastercard:_____

Exp. Date:_____ Security code_____

I hereby authorize the above card to be billed for services provided by Dr. Julia Samton.

Name/signature_____

Billing information (if distinct from above home address)

Name on card_____

Address _____

City_____ State_____

Zip code_____

Cancellation policy. I do have a cancellation policy. Currently, clients are not responsible for payment as long as cancellation occurs within 48 hours of the anticipated appointment. You will be responsible for the appointment fee only if your time is not filled. Please feel free to discuss my cancellation policy with me at any time.