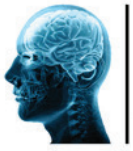

Midwest
Neurology Associates
Samer Kassar M.D.

NEW PATIENT INFORMATION

Patient Name _____
Last First MI

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Email _____ Marital Status _____ SSN _____

M/F _____ Birthday _____ Age _____

Emergency Contact Name _____

Relation _____ Emergency Contact Phone _____

Employer _____ Phone _____ Insurance _____

Spouse Name _____ Birthday _____

Insurance Policy Holder

Name _____ Relation _____

Phone _____ Address _____ SSN _____

Responsible Party (other than patients)

Name _____ Phone _____

Relationship to patient _____ Birthday _____

Pharmacy Name _____ Location zip code _____ Phone _____

Primary Physician _____ Phone _____

Reffered by _____

Authorization to Pay Benefeits to Provider

I request that payment of authorized Medicare benefeits and all Non-Medicare benefeits be made either to me or my behalf for any services furnished me by Midwest Neurology Associates, PC., including my physician services. I quthorize any holder of medical or other information about me to release to the Health Care Financing Administration, it's agents and all other respective agents information needed to determine these benefeits for related services. I understand that I am financially responsible to Midwest Neurology Associates, P.C., for services not covered by my policies. In the event that my account is turned to collection, I agree to pay all collection costs and attorney's fees. According to the HIPAA guidelines, I acknowledge that I have had avaulable and/or recieved the Notice of Privacy Practices from Midwest Neurology Associates, P.C.

Signature _____ Date _____