Schwerpunktpraxis für Neuropädiatrie

Prof. Dr.med. Stephan A. König

Schillerplatz 12-14
67071 Ludwigshafen
Fax: 0621- 690878-29
Telefon: 0621- 690878-0
www.neurologie-koenig.de
info@neurologie-koenig.de
www.neurologisch-krankes-kind.de

Patient Information Sheet

Patient Information

Last Name_____ First Name_____MI____

Address_____City_____ State___

Home Phone_____ Cell_____ Work_____

Email_____ Date of Birth_____ Gender_____

Marital Status___Married ___Single ___Widowed ___Divorced ___Separated Social Security Number_____

Race ___American Indian ___Asian ___Black or African American ___Native Hawaiian ___White ___Other

Ethnicity ___Cambodian ___Filipino ___Hispanic/Latino ___Non-Hispanic

Dependent?_____ If yes, Guardian's Name_____

Address_____ Phone_____

Responsible Party _____ Address_____

City_____ State_____ Relationship to Patient _____

Employer

Employment Status ___Employed ___Self-employed ___Retired ___On active military duty ___Unknown

Employer Name_____Employer Address_____

Employer phone_____ Position_____

Authorization to Release Medical Information

Please check one

____ I authorize One to One to release my medical information including the diagnosis, examination rendered to me, treatment to:

____ Spouse_____ Child(ren)_____Other_____

____ Information is not be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Insurance

Primary Insurance Carrier_____ Address_____

Insured's Name_____ Relationship to Patient_____

Insured's ID Number _____Group Number_____

Preferred Method of Contact

Preferred Method of Contact ___ Phone ___Email ___Patient Portal ___Other

Do we have your permission to leave a detailed message including test results? ___Yes ___No

Phone number to leave messages_____ Email to leave messages_____

Signature

I verify that the above information is factual and true to the best of my knowledge. I understand that proof of insurance and/or copay, if applicable, is due at the time of service.

Patient or Legal Guardian Signature_____ Date_____

I further agree to the following conditions:
Appointments have to be cancelled 3 days prior to the booked time. Otherwise charges of 350 EUR will be due.
I have also noticed the costs declared in the Internet.

General Consent to Treat

I consent to treatment by One to One Physicians and staff for my healthcare, including but not limited to exams, testing, medications, and minor procedures. I acknowledge and agree no guarantees have been made to me as the results or outcome of my care. I understand that State Law requires physicians to report certain communicable diseases to the Health Department.

If at any time I have questions about my examination, diagnosis, or treatment, I will not proceed until my questions have been answered to that I am fully informed. I understand that giving the providers and nurses all relevant information is important to my proper diagnosis and treatment. I understand complete compliance with my provider's instructions is critical to the success of any treatment prescribed.

I authorize one to one Health to release my health information to my health plan or to a health and wellness provider approved by my health plan for purposes of advising me concerning appropriate measures to maintain or improve my health or any condition reflected in my records. I authorize One to One Health to release information to my designated insurance plan for the purpose of health plan administration, including receiving or making payment for services rendered on my behalf. I understand a patient is responsible for all charges incurred, subject to contract and program rules, regardless of my insurance status. If it becomes necessary to send this account to collections, the patient will be responsible for all additional charges.

_____ _____

Patient Signature (or Parent/Guardian if a minor) Date