AFFILIATED NEUROLOGY CENTER

25982 Pala, Suite 150
Mission Viejo, CA 92691

Telephone: 949-586-5500
Fax: 949-586-1600

PATIENT RESPONSIBILITY INFORMATION

Name: ________________________________

Address: ____________________________________City___________State______Zip_______

Telephone (____) ______-___________

Primary insurance information:

Name of Insurance:_____________________________Name of insured:___________________

Policy number:________________________________Effective date:______________________

Phone #________________________Address:____

Secondary Insurance Information:

Name of Insurance:_____________________________Name of insured:__________________

Policy number:_________________________________Effective date:____________________

Phone #_______________________ Address:____

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Please list any other insurance coverage or payment options that we need to be aware of:

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As a courtesy to our patients, our office will verify and send billing to your insurance company. Please be aware that you are responsible for payment of services rendered by our office. Co-payments and deductible amounts will be expected when services are rendered.

____ ________________________

Signature **Date**