ROCKET BALANCE

Center for Dizziness and Imbalance

5 N Maple Avenue, Suite 100
La Plata, Maryland 20646
410-696-3669 ph | 410-695-3769 fax

☐ First visit
☐ Follow-up
☐ Annual check

PATIENT INTAKE

Patient's Name _____ Today's Date _____

DOB _____ SSN _____ Gender _____ Age _____

Street Address _____

City _____ State _____ Zipcode _____

Home phone _____ Cell phone _____ Email _____

Preferred method of contact _____

Is it okay to leave reminder messages on your voicemail? Y N

Is it okay to email reminder messages? Y N

Occupation _____ Employer _____

Marital Status _____ Spouse's Full Name _____

Emergency Contact _____ Phone Number _____

Relationship to Patient _____

Primary Care Physician _____ Phone Number _____

Referring Physician _____ Phone Number _____

May we send today's test results directly to your physicians listed above? Y N

How did you hear about our office? _____

INSURANCE INFORMATION Please provide insurance cards upon arrival.

Primary Insurance Company		Secondary Insurance Company	
ID Number		ID Number	
Group Number		Group Number	
Name of Policy Holder		Name of Policy Holder	
Policy Holder's DOB		Policy Holder's DOB	

RESPONSIBLE PARTY FOR BILLING

Responsible Party's Full Name _____

Home Address _____

Phone Number _____ Relationship to Patient _____

PATIENT PRIVACY POLICY

I hereby give consent to Rocket Balance, LLC to disclose test results to the physician(s) named on the previous page and my personal information disclosed to the insurance company(s) listed on the previous page and their agents for the purpose of obtaining payment for services and determining insurance benefits payable. I understand that I am fianancially responsible for all charges whether or not paid for and/or covered by my insurance company(s). I authorize the use of my signature on all submissions. I understand that I have the option to request a hard copy of the full privacy policy.

Signature _____ Date _____

I hereby authorize Rocket Balance, LLC to reasonable use and/or disclose my health information to execute treatment, activities of billing and payment, and other healthcare operations as necessary. I understand that my health information specifically identifies me or can be used to identify me. While I understand that this authorization is voluntary, I also understand that if I refuse to consent, services may be withheld from me. I also understand that I have the ability to revoke this consent at any time and the revocation must be received in writing. I further understand that any actions taken by Rocket Balance, LLC prior to receiving written revocation will not be affected.

Signature _____ Date _____

I hereby authorize Rocket Balance, LLC to disclose information about my care and/or account to the following individuals:

Spouse		Care Taker	
Primary Care Physician		Other	
Neurologist		Other	
ENT Physician		Other	

Signature _____ Date _____

I hereby authorize payment of medical benefits billed to my insurance to be issued to Rocket Balance, LLC. I accept responsibility for payment for any services(s) or product(s) provided to me that is or are not covered by my insurance company(s). I also accept responsibility for fees that exceed the payment made by insurance company(s) if Rocket Balance, LLC does not participate with my insurance or if I otherwise agree in writing. I agree to pay all copayments, coinsurances, and/or deductibles in full at the time services are rendered.

The above policy will remain in effect for as long as I am under the care of a provider at Rocket Balance, LLC, or if otherwise notified. My signature represents my review, understanding, and acceptance of the above billing policies.

Signature _____ Date _____

Printed Name _____