

*California Neurological Specialists*  
**Lorne S. Label, M.D., M.B.A., F.A.A.N. A**  
Medical Corporation, Diplomate, American Board of  
Psychiatry and Neurology

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**PATIENT REGISTRATION**

PLEASE PRINT

Patient: \_\_\_\_\_ Age \_\_\_\_\_ Sex: \_\_\_\_\_ M \_\_\_\_\_ F  
Primary Language Spoken: \_\_\_\_\_ English \_\_\_\_\_ Spanish \_\_\_\_\_ Other \_\_\_\_\_  
Driver's Lic.No. \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Birthdate \_\_\_\_/\_\_\_\_/19 Social Security No. \_\_\_\_\_ Marital Status: \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ W  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Referred By \_\_\_\_\_ Reason For Visit \_\_\_\_\_  
Date of Onset \_\_\_\_\_

**SPOUSE INFORMATION**

Spouse's Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Driver's Lic. No. \_\_\_\_\_ Home Phone No. \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse's  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Work Phone No. \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Carrier \_\_\_\_\_ Address \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ Group No. \_\_\_\_\_ Cert. No. \_\_\_\_\_  
Secondary Ins. Carrier \_\_\_\_\_ Group No. \_\_\_\_\_ Cert. No. \_\_\_\_\_  
Medicare No. \_\_\_\_\_

**BILLING INFORMATION**

Name of Person Responsible For Payment \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Area Code and Phone No. \_\_\_\_\_

**FINANCIAL & SERVICES AGREEMENT**

**PLEASE READ AND SIGN THE FOLLOWING:**

I do hereby authorize Lorne S. Label, M.D., and his medical staff to render whatever services necessary for the care of myself or my family member. I have engaged you as my personal physician, with the understanding that you, personally, will provide the care I need whenever you are available. Considering this, I release you from any liability that may arise as a result of any care that may be provided by any physician to whom you refer me or covering you in your absence.

I hereby authorize payment directly to California Neurological Specialists (CNS) or Lorne S. Label, M.D., for any medical services. I understand that I am financially responsible for charges. CNS will bill your private insurance as a courtesy and will allow 45 days for payment. I also authorize Lorne S. Label, M.D., or CNS to furnish my insurance company with full information regarding the treatment rendered. I/ WE understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements. CNS may add one and one half percent (1.5%) per month to any balance owed. Reasonable collection charges and/or attorney fees will be added to the outstanding amount owed CNS in the event of default.

There will be a \$75.00 fee for missing a scheduled appointment or cancelling with less than 24 hours notice. It is our office policy to waive the first charge. All future "NO SHOWS" without the notice of cancellation previously mentioned herein, will result in a charge of \$75.00.

No fee will be waived for neurologic testing requiring technician support. Canceled appointment with less than 24 hours notice or "NO SHOW" will result in a charge of \$125.00.

It is the policy of this medical practice that we will adopt, maintain and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California law.

Notice of Privacy Practices: It is the policy of this medical practice that a notice of privacy practices must be published, that this notice be provided to all subject individuals at the first patient encounter if possible, and that all uses and disclosures of protected health information be done in accord with this organization's notice of privacy practices. It is the policy of this medical practice to post the most current notice of privacy practices in our "waiting room" area, and to have copies available for distribution at our reception desk.

If this policy is not clear, please ask for clarification.

Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PATIENT (Parent or Guardian if patient under 18yrs.)