METROPOLITAN NEUROEAR GROUP

HEARING & BALANCE DISORDERS
FACIAL NERVE DISORDERS
ACOUSTIC NEUROMAS, COCHLEAR IMPLANTS
HEAD & NECK SKULL BASE SURGERY

SANJAY PRASAD, M.D., F.A.C.S.
Diplomate American Board of Otolaryngology
Subspecialty Otology, Neurotology/Cranial Base Surgery
www.earsite.com

Dear Prospective Patient,

Thank you for choosing Dr. Sanjay Prasad and Metropolitan NeuroEar Group for your medical care. In order to maximize your success and achieve the highest outcomes possible, we ask for your cooperation in the following areas:

1. Enclosed you will find the forms that are required to be completed and returned to our office prior to scheduling your appointment. You can either fax, mail, or e-mail the forms back to us.

E-Mail:	bhungerford@earsite.com
Fax:	301-560-3469
Mail:	Metropolitan NeuroEar Group 1101 Wootton Parkway, Suite 900 Rockville, MD 20852 Attn: Barbara Hungerford

2. Please review the enclosed copy of Metropolitan NeuroEar Group's Notice of Privacy Practices. You will be asked to sign an acknowledgement on your first visit.

3. For your initial appointment, please arrive 15 minutes early to complete any remaining paperwork. Please bring the following items to your first appointment:

- Driver's license or another photo ID
- Health insurance card(s)

4. It is important that you are on time for your appointments. If you think you may be late for your appointment, please call the office.

5. Please notify the office at least 24 hours in advance if you need to cancel an appointment. You may also be responsible for a "no show/cancellation" charge.

Thank you for your cooperation and if you have any questions, please call the office at 301-493-9409.

Sincerely,
Sanjay Prasad, MD, PA and Metropolitan NeuroEar Group

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PATIENT REGISTRATION

please print clearly

PATIENT INFORMATION

DATE: _____

NAME: _____ □ MALE □ FEMALE

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____ E-MAIL ADDRESS: _____

SOCIAL SECURITY #: _____ OCCUPATION: _____

MARITAL STATUS: □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED

SPOUSE/PARENT'S NAME: _____ PHONE NUMBER: _____

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

INSURANCE INFORMATION

NAME OF SUBSCRIBER: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ WORK PHONE: _____

PRIMARY INSURANCE COMPANY: _____

DO YOU HAVE SECONDARY HEALTH INSURANCE? ☐ YES ☐ NO

SECONDARY HEALTH INSURANCE COMPANY: _____

NAME OF SUBSCRIBER: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

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PATIENT AUTHORIZATION/CONSENT FOR TREATMENT

The information I provided on the patient registration form is true to the best of my knowledge I do herby give consent for Sanjay Prasad, MD, PA d.b.a. Balance Center of Maryland to provide physical therapy services considered necessary and appropriate in evaluating and treating my physical condition. I authorize my health insurance benefits to be paid directly to Sanjay Prasad, MD, PA. I understand that I am financially responsible for any balance. I also authorize Sanjay Prasad, MD, PA d.b.a. Balance Center of Maryland or insurance company to release any information required to process my claims.

_____ _____
Patient/Guardian Signature Date

RELEASE OF INFORMATION

I understand that all information concerning my care is confidential. I authorize Sanjay Prasad, MD, PA d.b.a. Balance Center of Maryland to release my information to health care providers , payors and individuals related to the provision of services that may have an effect on the continuation of plan of care or in the benefits payable for services rendered.

_____ _____
Patient/Guardian Signature Date

MEDICAL TEST RESULTS

I understand that if I have not had a follow-up office visit to review my test results or have not received a phone call from Metropolitan NeuroEar Group/Balance Center of Maryland, it is my responsibility to contact the office to receive my tests results two weeks after the test was performed.

_____ _____
Patient/Guardian Signature Date

INSURANCE COVERAGE OF COMPUTERIZED DYNAMIC POSTUROGRAPHY (CPT 92548)

Computerized Dynamic Posturography (CDP) is a diagnostic test performed at Metropolitan NeuroEar Group/Balance Center of Maryland. CDP is a series of three tests that objectively measure your sensory and motor systems and how they contribute to balance. The results, combined with information from your medical history, physical examination, and other diagnostic tests, will allow the physical therapist to individualize your plan of care. CDP charges are usually, but not always, paid by health insurance. If your insurance does not cover CDP, you will be asked to pay for this test. The usual and customary charge is $650; however, we offer a reduced rate of $200 due at the time of service. ACH payment plan available.

By signing below, I agree to pay for the Computerized Dynamic Posturography (CDP) test performed by Metropolitan NeuroEar Group/Balance Center of Maryland if the test is not covered by my insurance company.

_____ _____
Patient/Guardian Signature Date

If you would like additional information on Computerized Dynamic Posturography (CDP), please contact the medical front desk receptionist, Barbara Hungerford.

The Tower Building
1101 Wootton Parkway, Suite 900
Rockville, MD 20852-1059
301 493-9409

Prosperity Medical Center
8505 Arlington Blvd, Suite 270
Fairfax, VA 22031-4621
703 352-3758