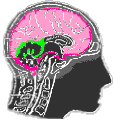


EMERY NEUROSCIENCE CENTER

Patient Name:					Chart #:	
DOB:		Age:			Date:	

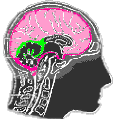
PATIENT INFORMATION

(Name and Birth Date is only necessary if the information on the header above is not correct):			
Patient's last name:	First:	Middle:	Patient Birth Date:

Sex: ❑ Male ❑ Female	Marital status (circle one) Single / Married / Divorced / Separated / Widowed		
Primary Care Physician:			Office Phone: ( )
Referring Physician:			Office Phone: ( )
Street address:		Social Security Number:	Home Phone: ( )
City:	State:	Zip Code:	Cell Phone: ( )
Occupation:	Employer:		Employer Phone: ( )

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home Phone: ( )	Work Phone: ( )



EMERY NEUROSCIENCE CENTER

Patient Name:					Chart #:	
DOB:		Age:			Date:	

Allergies, X-rays, Surgeries

Are you allergic to:						
Medicine			Medicine			Any Foods:
Penicillin	☐Yes	☐No	Antitoxin	☐Yes	☐No	
Sulfa Drugs	☐Yes	☐No	Mycins	☐Yes	☐No	
Aspirin	☐Yes	☐No	Other Antibiotics	☐Yes	☐No	
Codeine	☐Yes	☐No	Adhesive Tape	☐Yes	☐No	
Morphine	☐Yes	☐No	Any Other Drugs:			
Tetanus	☐Yes	☐No				

Have you ever had X-rays, MRI scans, CAT scans, or other radiological studies of your:		
	Date:	Findings:
Skull/Head		
Back		
Neck		
Chest		
Extremities		
Other Area(s)		

If you have had surgery to the following areas, please enter date/name of hospital in space provided:			
Focus Operation:	Date:	Hospital	
Tonsils			
Ovary(ies)			
Gall Bladder			
Uterus			
Appendix			
Hemorrhoids			
Other Operations			
Have you had a transfusion?		☐ Blood ☐ Plasma	Date:
Any other illnesses or hospitalizations:		Date:	Hospital:

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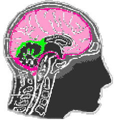


EMERY NEUROSCIENCE CENTER

Patient Name:					Chart #:	
DOB:			Age:		Date:	

Emotions

Prior to your neurological symptoms, have you felt/or have you been treated for:			
Emotion/Action	Response	Emotion/Action	Response
Depressed		Jumpy	
Irritable		Jittery	
Anxious		Difficulty Concentrating	

Since the onset of your *current* neurological symptoms, have you felt:			
Emotion/Action	Response	Emotion/Action	Response
Depressed		Jumpy	
Irritable		Jittery	
Anxious		Difficulty Concentrating	

Have you ever been treated for the ***same*** or ***similar*** condition for which you are currently seeking treatment?
Please Explain:

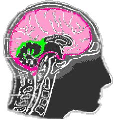
Have you ever been treated by a neurologist before?
Why? :

Have you ever been treated by a neurosurgeon before?
Why? :

Have you ever been treated by a chiropractor before?
Why? :

Previous car accidents/work related accidents/slip-and-fall accidents leading to medical treatment, emergency room visit, etc:

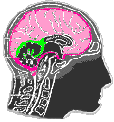
Prior to your current complaints have you ever had any of these medical problems?	
Head Injury:	
Neck Injury:	
Middle Back Injury:	
Lower Back Injury:	
Arm/leg Injury:	



EMERY NEUROSCIENCE CENTER

Patient Name:					Chart #:	
DOB:		Age:			Date:	

Have you ever had:		When?	Since Injury?
Chest Pain	☐ Yes ☐ No		☐ Yes ☐ No
Angina	☐ Yes ☐ No		☐ Yes ☐ No
Spiting up blood	☐ Yes ☐ No		☐ Yes ☐ No
Night Sweats	☐ Yes ☐ No		☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No		☐ Yes ☐ No
At night	☐ Yes ☐ No		
With exertion	☐ Yes ☐ No		
Palpitations	☐ Yes ☐ No		☐ Yes ☐ No
Fluttering Heart	☐ Yes ☐ No		☐ Yes ☐ No
Swelling of hands	☐ Yes ☐ No		☐ Yes ☐ No
Swelling of feet	☐ Yes ☐ No		☐ Yes ☐ No
Swelling of ankles	☐ Yes ☐ No		☐ Yes ☐ No
Extreme tiredness	☐ Yes ☐ No		☐ Yes ☐ No
Extreme weakness	☐ Yes ☐ No		☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No		☐ Yes ☐ No
Kidney Stones	☐ Yes ☐ No		☐ Yes ☐ No
Bladder Disease	☐ Yes ☐ No		☐ Yes ☐ No
Blood in urine	☐ Yes ☐ No		☐ Yes ☐ No
Problems w/urination	☐ Yes ☐ No		☐ Yes ☐ No
Abnormal thirst	☐ Yes ☐ No		☐ Yes ☐ No
Prostate trouble	☐ Yes ☐ No		☐ Yes ☐ No
Stomach problems	☐ Yes ☐ No		☐ Yes ☐ No
Stomach ulcers	☐ Yes ☐ No		☐ Yes ☐ No
Indigestion	☐ Yes ☐ No		☐ Yes ☐ No
Frequent Gas	☐ Yes ☐ No		☐ Yes ☐ No
Frequent Belching	☐ Yes ☐ No		☐ Yes ☐ No
Rectal bleeding	☐ Yes ☐ No		☐ Yes ☐ No
Constipation	☐ Yes ☐ No		☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No		☐ Yes ☐ No
Parasites/Worms	☐ Yes ☐ No		☐ Yes ☐ No

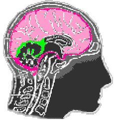


EMERY NEUROSCIENCE CENTER

Patient Name:					Chart #:	
DOB:		Age:			Date:	

Review of System

Have you ever had:		When?	Since Injury?
Eye Disease	☐ Yes ☐ No		☐ Yes ☐ No
Eye Injury	☐ Yes ☐ No		☐ Yes ☐ No
Impaired Sight	☐ Yes ☐ No		☐ Yes ☐ No
Ear Disease	☐ Yes ☐ No		☐ Yes ☐ No
Ear Injury	☐ Yes ☐ No		☐ Yes ☐ No
Impaired Hearing	☐ Yes ☐ No		☐ Yes ☐ No
Trouble with nose	☐ Yes ☐ No		☐ Yes ☐ No
Trouble with sinuses	☐ Yes ☐ No		☐ Yes ☐ No
Trouble with mouth	☐ Yes ☐ No		☐ Yes ☐ No
Trouble with throat	☐ Yes ☐ No		☐ Yes ☐ No
Fainting spells	☐ Yes ☐ No		☐ Yes ☐ No
Convulsions	☐ Yes ☐ No		☐ Yes ☐ No
Paralysis	☐ Yes ☐ No		☐ Yes ☐ No
Dizziness	☐ Yes ☐ No		☐ Yes ☐ No
Headaches	☐ Yes ☐ No		☐ Yes ☐ No
Frequent	☐ Yes ☐ No		
Severe	☐ Yes ☐ No		
Enlarged Glands	☐ Yes ☐ No		☐ Yes ☐ No
Thyroid	☐ Yes ☐ No		☐ Yes ☐ No
Overactive	☐ Yes ☐ No		
Under active	☐ Yes ☐ No		
Skin Disease	☐ Yes ☐ No		☐ Yes ☐ No
Cough	☐ Yes ☐ No		☐ Yes ☐ No
Frequent	☐ Yes ☐ No		
Chronic	☐ Yes ☐ No		
Appendicitis	☐ Yes ☐ No		☐ Yes ☐ No
Liver Problems	☐ Yes ☐ No		☐ Yes ☐ No
Gall Bladder Disease	☐ Yes ☐ No		☐ Yes ☐ No
Colitis	☐ Yes ☐ No		☐ Yes ☐ No
Hemorrhoids	☐ Yes ☐ No		☐ Yes ☐ No



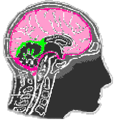
EMERY NEUROSCIENCE CENTER

Patient Name:					Chart #:	
DOB:		Age:			Date:	

Social History

1.	Do you smoke?	☐ Cigarettes PPD ☐ Cigars ☐ Pipe ☐ Tobacco ☐ Snuff	
2.	Do you drink alcohol?	Ounces per week	
3.	Do you drink caffeine?	☐ Coffee cups per day ☐ Tea Cups per day	
4.	Do you exercise?	How? Please Explain:	
5.	Do you like your work?	☐ Yes ☐ No	How many hours of work per day?
6.	Do you work?	☐ Inside ☐ Outside	
7.	Do you watch TV?	☐ Yes ☐ No	Hours per day
8.	Do you read?	☐ Yes ☐ No	Hours per day
9	Do you take vacations?	☐ Yes ☐ No	Weeks per year
10.	Have you ever been treated for drug abuse?	☐ Yes ☐ No	
11.	Have you ever been treated for alcoholism?	☐ Yes ☐ No	
12.	Change in appetite?	☐ Yes ☐ No	Explain:
13.	Change in eating habits?	☐ Yes ☐ No	Explain:
14.	Change in bowel movements?	☐ Yes ☐ No	Explain:
15.	Change in stools?	☐ Yes ☐ No	Explain:
16.	Do you take thyroid medicine?	☐ Yes ☐ No	Explain:
17.	Do you take insulin?	☐ Yes ☐ No	Explain:
18.	Do you take sedatives?	☐ Yes ☐ No	Explain:
19.	Do you take tranquilizers?	☐ Yes ☐ No	Explain:
20.	Do you take sleeping pills?	☐ Yes ☐ No	Explain:
21.	Do you take aspirin?	☐ Yes ☐ No	Explain:
22.	Do you take cortisone?	☐ Yes ☐ No	Explain:
23.	Do you take laxatives?	☐ Yes ☐ No	Explain:
24.	Do you take vitamins?	☐ Yes ☐ No	Explain:
25.	Do you take oral contraceptives?	☐ Yes ☐ No	Explain:
26.	Do you take hormone therapy?	☐ Yes ☐ No	Explain:

Height:	Feet Inches	
Current Weight:	Pounds	
Weight 1 year ago:	Pounds	
Maximum Weight:	Pounds	When:



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Patient Name:					Chart #:	
DOB:		Age:			Date:	

Family History

Age (if living):			
Father:	Mother:	Spouse:	Brother(s):
Sister(s):			Children:

Age of death:			
Father:	Cause of death:	Mother:	Cause of death:
Relationship:	Age at death:	Cause of death	
Other Members Family			
Relationship:	Age at death:	Cause of death	
Relationship:	Age at death:	Cause of death	
Relationship:	Age at death:	Cause of death	

Does anyone in your family currently have or had the following illnesses?		
		Relationship to Patient
Cancer	☐Yes ☐No	
Tuberculosis	☐Yes ☐No	
Diabetes	☐Yes ☐No	
Heart Trouble	☐Yes ☐No	
High Blood Pressure	☐Yes ☐No	
Stroke	☐Yes ☐No	
Epilepsy	☐Yes ☐No	
Nervous Breakdown	☐Yes ☐No	
Asthma	☐Yes ☐No	
Hay Fever	☐Yes ☐No	
Blood Disease	☐Yes ☐No	
Hives	☐Yes ☐No	
High Cholesterol	☐Yes ☐No	

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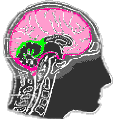

EMERY NEUROSCIENCE CENTER

Patient Name:					Chart #:	
DOB:		Age:			Date:	

Past Medical History

(PLEASE LIST *ONLY* IF YOU HAD BEFORE YOUR CURRENT COMPLAINTS OR INJURY)

Have you had:	Age:	Date:	Have you had:	Age:	Date:
Scarlet Fever			Diabetes		
Scarlatina			Hay Fever		
Diphtheria			Asthma		
Rheumatic Fever			Hives		
Pneumonia			Eczema		
Pleurisy			High Blood Pressure		
Fever Fluctuation			Low Blood Pressure		
Arthritis			Frequent Infections		
Rheumatism			Concussion		
Bone Disease			Head Injury		
Joint Disease			Underactive Thyroid		
Neuritis			Overactive Thyroid		
Neuralgia			Food Poisoning		
Bursitis			Tuberculosis		
Sciatica			Heart Attack		
Polio			Other Heart Problems		
Meningitis			Epilepsy		
Gonorrhea			High Cholesterol		
Syphilis			Cancer		
Anemia			Migraine Headaches		
Jaundice			Other Headaches		

Drug Poisoning	Age	Date		Explain		
Broken Bones	Age	Date		Which Bone(s)		
Deliveries	Age	Date		# of Deliveries		
Tested for HIV?	☐ No	☐ Yes	☐ Positive	☐ Negative	T-Cell Count	Viral Load

Other Disease / Medical Problems not listed	Date:

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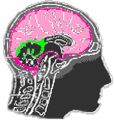

EMERY NEUROSCIENCE CENTER

Patient Name:					Chart #:	
DOB:		Age:			Date:	

Neurological Evaluation Liability Patient's History

Records Available			
☐ Brought by patient	☐ Sent by doctor's office	☐ Sent by attorney's office	☐ Sent by ins. Company.
Patient referred by:			

Work Status					
Place of Employment			Occupation:		
☐ Full-time	☐ Part-time		☐ Light-duty	☐ Full-duty	
☐ Not working Date last Worked:	☐ Patient has been seen previously in this office for:				
This year old	☐ Right		☐ Left -handed		
☐ Married	☐ Single	☐ Divorced	☐ Separated	☐ Widowed	
☐Asian	☐Hispanic	☐Caucasian	☐ Black	☐ Other:	
☐ Male			☐Female		
Language:	☐ English ☐Spanish ☐ Creole ☐ French ☐ Italian ☐German Other:				
Seen With:	☐ Interpreter ☐ Spouse ☐Parent ☐ Other:			Sex: ☐ Male ☐ Female	
Accident occurred on		Patient remembers events: ☐ Prior to incident ☐ Following the incident			
The patient describes the accident:					
Loss Of Consciousness:	☐ Yes	☐ No	Time:		
Went to:	☐ Continued to work ☐ Home ☐ Worker's compensation clinic ☐ Hospital				
	Other:		Was taken by:		
Was Used:	☐ Back-board	☐ Cervical collar	Studies obtained:		
Patient:	☐ Was released the same day		☐ Admitted	☐ Stayed overnight for days, and seen by Dr.	
Medications given at hospital:					
Any other treatment received:					
Other information regarding patient's injuries:					
Patient (for these injuries):	☐ Has not been seen previously by other doctors ☐ Has been treated by: For these complaints:				
Symptoms:	☐ With relief	☐ Without relief			

The patient has a previous history of accident / injuries:			
1.	Dated:	Injuries:	
☐ Workmen's Compensation		☐ Auto Accident	Other:
Diagnosis(es):			
2.	Dated:	Injuries:	
☐ Workmen's Compensation		☐ Auto Accident	Other:
Diagnosis(es):			
3.	Dated:	Injuries:	
☐ Workmen's Compensation		☐ Auto Accident	Other:
Diagnosis(es):			
Other Notes:			

EMERY NEUROSCIENCE CENTER

Patient Name:					Chart #:	
DOB:		Age:			Date:	

REHABILITATIVE

Are you currently receiving physical therapy?	If so where?

Are you currently receiving occupational therapy?	If so where?

Are you currently receiving any other types of treatment? (For example, chiropractic manipulation, acupuncture, biofeedback, homeopathic, etc.)	If so, what type of treatment and where?

Current Medications			
Name	Dose	How often do you take the medicine	Doctor prescribing medicine

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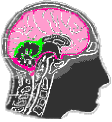

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Patient Name:					Chart #:	
DOB:		Age:			Date:	

Mark Area(s) affected

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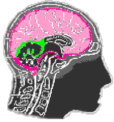

EMERY NEUROSCIENCE CENTER

Patient Name:					Chart #:	
DOB:		Age:			Date:	

Neurological Symptom Checklist

Please check *ONLY* the areas where you are having neurological problems that you would like Dr. Emery to evaluate. A questionnaire for each area you check will then be given to you which you are to bring into the examining room with you so that Dr. Emery will evaluate your specific neurological symptoms.

Are your neurological symptoms a result of an accident of any kind?	
☐ YES	☐NO

If your symptom is a result of an accident then please specify:		
☐ Auto Accident		☐ Slip and Fall
☐ Workmen's Compensation		
☐ Other	Describe:	

☐	HEADACHES
☐	NECK PAIN
☐	MIDDLE BACK PAIN
☐	LOW BACK PAIN
☐	VISION PROBLEMS
☐	VERTIGO OR DIZZINESS
☐	WALKING PROBLEMS
☐	NUMBNESS OR WEAKNESS OF FACE
☐	NUMBNESS OR WEAKNESS OF ARMS/HANDS
☐	NUMBNESS OR WEAKNESS OF LEGS/FEET
☐	MEMORY DISTURBANCE
☐	DEPRESSION
☐	ANXIETY
☐	TREMOR
☐	SEIZURE OR SPELLS OF LOSS OF CONSCIOUSNESS
☐	SPEECH DIFFICULTY
☐	SLEEP DISTURBANCE

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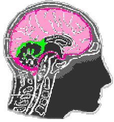

EMERY NEUROSCIENCE CENTER

Patient Name:					Chart #:	
DOB:		Age:			Date:	

Patient Consent Form

☐	I consent to have my medical records provided to my other active treating physicians.
☐	I consent to have my medical records provided to physicians whom Dr. Emery refers me to for additional treatment or whom Dr. Emery wants a second opinion, e.g., a Professor of Neurology.
☐	I consent to have my medical records provided to Social Security Disability (should the need ever arise.)
☐	I consent to have my medical records provided to any attorney who represents me either in civil litigation (personal injury) or in a Workman's Compensation claim. I understand that in a Workmen's Compensation claim a Defense Attorney (the attorney representing the company you work for) as well as adjustors, nurse case managers, secretaries, or any other personnel working for the Insurance Company have the right to my medical records as well as the right to talk with Dr. Emery without my permission, according to Florida State Law.
☐	I consent to have my medical records provided to any and all of my family members if requested.
☐	I consent to have my medical records provided to my insurance company should they request them for billing purposes or should they request them prior to authorizing a test or tests that Dr. Emery has recommended.
☐	I consent to have my medical records provided to any Law Enforcement agency should a situation arise in which Dr. Emery feels it would be in my best interest to do so, e.g. I get involved in a bad accident and a law enforcement agency wants to know what my Neurological condition is or what medicines I am taking.
☐	I consent to being Video taped if Dr. Emery orders a Video EEG.
☐	None of These options

____
Signature   Date

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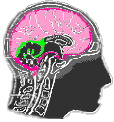


EMERY NEUROSCIENCE CENTER

Patient Name:					Chart #:	
DOB:		Age:			Date:	

Doctor's Lien

To: Attorney:	
Date of Accident:	

RE: MEDICAL REPORTS AND DOCTOR'S LIEN
(In this document "doctor" means Dr. Waden E. Emery III, M. D., P. A. and any of it's nurses, staff, agents, or employees.)

I DO HEREBY AUTHORIZE WADEN E. EMERY III, M.D. TO FURNISH YOU, MY ATTORNEY, WITH A FULL REPORT OF HIS EXAMINATION, DIAGNOSIS, TREATMENT, PROGNOSIS, ETC., OF ME IN REGARD TO THE ACCIDENT IN WHICH I WAS INVOLVED.

I HEREBY AUTHORIZE AND DIRECT YOU, MY ATTORNEY, TO PAY DIRECTLY TO SAID DOCTOR SUCH SUMS AS MAY BE DUE AND OWING HIM FOR MEDICAL SERVICES, AND ANY DIAGNOSTIC TESTING OR APPLIANCE DEEMED NECESSARY BY THE DOCTOR AND RENDERED ME BOTH BY REASON OF THIS ACCIDENT AND BY REASON OF ANY OTHER BILLS THAT ARE DUE HIS OFFICE AND TO WITHHOLD SUCH SUMS FROM MY SETTLEMENT, JUDGMENT, OR VERDICT AS MAY BE NECESSARY TO ADEQUATELY PROTECT SAID DOCTOR. I DO HEREBY FURTHER GIVE A LIEN ON MY CASE TO SAID DOCTOR FOR ANY AMOUNTS DUE AND OWING SAID DOCTOR AGAINST ANY AND ALL PROCEEDS OF ANY SETTLEMENT, JUDGMENT OR VERDICT WHICH MAY BE REPAID TO YOU, MY ATTORNEY, OR MYSELF AS THE RESULT OF THE INJURIES FOR WHICH I HAVE BEEN TEASTED OR INJURIES IN CONNECTION THEREWITH.

WITH REGARD TO FUNDS THAT MAY COME INTO THE ATTORNEY'S HANDS, WHETHER JOINTLY PABLE TO THE ATTORNEY OR NOT FROM MEDICAL PAYMENT PROVISIONS, PERSONAL INJURY PROTECTION PROVISIONS, HEALTH INSURANCE PROVISIONS, PAYMENTS BY H.M.O.'S OR LIKE PROVISIONS PAID PURSUANT TO CONTRACT, YOU, THE ATTORNEY, ARE DIRECTED TO EITHER:

I. Pay to the above Doctor that portion of the funds received by you, the attorney, which
. correspond to the bills submitted to the payer and paid by the payer, or
2. Deliver the draft, check or money order to this doctor, along with the attorney's
. endorsement, if necessary, so that the doctor can obtain the patient's endorsement. All funds now owed
. the doctor will be paid back to the patient.

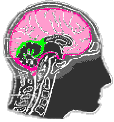
I FULLY UNDERSTAND THAT I AM DIRECTLY AND FULL RESPONSIBLE TO SAID DOCTOR FOR ALL MEDICAL BILLS SUBMITTED BY HIM FOR SERVICES RENDERED ME AND THAT THIS AGREEMENT AND LIEN IS MADE SOLELY FOR SAID DOCTOR'S ADDITIONAL PROTECTION AND IN CONSIDERATION OF HIS AWAITING PAYMENT AND I FURTHER UNDERSTAND THAT SUCH PAYMENT IS NOT CONTINGENT ON ANY SETTLEMENT, JUDGMENT OR VERDICT FROM WHICH I MAY EVENTUALLY PAY SAID FEE. I AGREE TO PAY ATTORNEY'S FEES AND COSTS OF ANY LITIGATION ARISING FROM THE ENFORCEMENT OF COLLECTION OF PAYMENT FOR MEDICAL SERVICES RENDERED ME BY SAID DOCTOR.

PATIENT'S SIGNATURE:____ DATE:____________________

THE UNDERSIGNED, BEING ATTORNEY OF RECORD FOR THE ABOVE PATIENT, DOES HEREBY AGREE TO OBSERVE ALLTHE TERMS OF THE ABOVE AND AGREE TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGMENT OR VERDICT AS MAY BE NECESSARY TO ADEQUATELY PROTECT SAID ABOVE-NAMED DOCTOR AND PAY SAW DOCTOR'S FEES PRIOR TO DISBURSEMENT OF ANY FUNDS FROM ANY OTHER COSTS OR CLAIMS. IN THE EVENT THE UNDERSIGNED ATTORNEY FAILS TO OBSERVE SAID TERMS, HE OR SHE AND HIS OR HER LAW FIRM WILL BE LIABLE FOR PAYMENT OF ANY BALANCE DUE TO FOR SERVICES RENDERED. FURTHER, I AGREE TO PAY ATTORNEY'S FEES AND COSTS OF ANY LITIGATION ARISING FROM THE ENFORCEM OR COLLECTION OF PAYMENT FOR MEDICAL SERVICES RENDERED BY SAID DOCTOR.

ATTORNEY'S SIGNATURE:____DATE:________________

5340 North Federal Highway Suite 205 ⌖ Lighthouse Point ⌖ Florida ⌖ 33064
Telephone: (954) 771 8300 ⌖ Fax (954) 771 4002
Web site: www.eneuro.med.pro



EMERY NEUROSCIENCE CENTER

Patient Name:					Chart #:	
DOB:		Age:			Date:	

PATIENT CONTRACT

The undersigned, whether he/she signs as guardian, agent or as patient, agrees that in consideration of the service to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of **Waden E. Emery III, M.D., P.A.**. Should the account be referred to an attorney or collection agency, the undersigned shall pay all reasonable attorney's fees and collections expense.

This authorization or photocopy thereof, will authorize the release of full and complete medical records when necessary to authorized physicians, hospitals, medical attendants, attorneys and/or insurance companies.

If the insured's policy prohibits direct payment to the physician, then the insured person/persons hereby instructs and directs the insurance company to make the payment out to the insured person/persons as patient and mail payment to the insured person/persons as follows:

c/o **Waden E. Emery III, M.D., P.A.**
5340 North Federal Highway
Suite 205
Lighthouse Point, Florida 33064

- The undersigned agrees to sign a letter of protection before the initial visit of the patient.
- The undersigned agrees to the approval of any and all attorneys representing the insured/patient at any time to sign a letter of protection. (A letter of protection is not acceptable as a guarantee of payment, it will only protect the bill from "delinquency" until the case is settled.)
- The insured will submit health insurance information along with auto insurance information.
- If the insured's personal injury protection benefits exhaust or have been exhausted for this case the undersigned agrees to allow **Waden E. Emery III, M.D., P.A**. to bill the insured's/patient's health insurance for the remaining balance and/or instead of the auto insurance.
- The undersigned agrees that assignment of each medical claim to any insurance or agent will be taken by **Waden E. Emery III, M.D., P.A.** and the undersigned is responsible for any difference, between the amount charged.
- The undersigned agrees that the total amount for each visit is due and payable at the time of service.
- The undersigned agrees telephone calls to this office requiring medical or medical staff attention will be subject to the appropriate levels of service charge.
- The undersigned agrees that a disruption fee will be charged if, at least, 24 hour notice of cancellation of an appointment is not given.

Waden E. Emery III, M.D., P.A. contracts with numerous insurance companies. In the event Waden E. Emery III M.D., P.A. contracts with your insurance company, Waden E. Emery III, M.D., P.A.'s contract with your insurance company will supersede this contract.

I/We have read, understood and agree to the above.

Print: Patient's Legal Name	Print: Agent or Guardian's Legal Name
Patient's Signature	Agent or Guardian's Signature
Date	Date