

**NEUROSCIENCE CONSULTANTS**  
DIPLOMATES, AMERICAN BOARD OF NEUROLOGY

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**MARK BRYER, M.D.**

Date: \_\_\_\_\_

Chief complaint: \_\_\_\_\_ Doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Day-Time Telephone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home #: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Sex: F or M    Marital Status: S M W Sep D    Spouse's Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone # \_\_\_\_\_

**Medical Providers:**

Primary Doctor's Name: \_\_\_\_\_ Telephone # \_\_\_\_\_

Fax: \_\_\_\_\_

Referring Physician's Name: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax: \_\_\_\_\_

**Employer Information:**

Employer Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Insurance 1:**

Type: HMO    PPO    POS    MEDICARE    W/C    AUTO

Insurance Name: \_\_\_\_\_ Telephone# \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

**Insurance 2:**

Type: HMO PPO POS MEDICARE W/C AUTO

Insurance Name: \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

**W/C AND AUTO ACCIDENTS:**

Claim #: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_

Telephone#: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

**Office Policies you should know:**

- A. Please alert our office of any insurance or address changes
- B. We are not Medicaid providers if your secondary insurance is Medicaid you will be responsible for your 20% and your annual deductible.
- C. Tests done outside our office (Blood, X-ray, Ct-Scan, MRI, etc) might take up to 2 weeks or longer for results. If you have not received a called back in two weeks call our office please.
- D. There is a \$10 charge for having blood drawn in our office. If you go to the laboratory directly you will not have to pay this charge.
- E. Co-payments and deductibles are due at the time of service. If we bill you the co-payment there will be a \$5.00 charge + your co-payment.
- F. We are not your insurance company so we are not aware of your insurance benefits. If you have any questions about your insurance benefits please contact the 1-800 number on your card. Thank you.
- G. If you are an HMO patient you will need an authorization or referral from your primary care physician or referring physician for every visit. It is your responsibility to make sure the referral is fax, mail, or brought to our office by the date of your appointment. Without the referral you will be responsible for all services. New patient visits are \$325 follow-up visits are \$140.
- H. If you are here due to a car accident we will need the claim number from your car insurance, claim address, and the phone number to the claim representative. Your health insurance does not cover these charges until your car insurance has processed the charges.
- I. If you would like to e-mail your doctor you must have a digital id with your e-mail. This is required for your confidentiality.
- J. We welcome your suggestions or complaints about our office. You may submit any suggestions or complaints by mail at 9090 SW 87 CT. suite 200 Miami, FL 33176 Att: Practice Manager or by e-mail at [hmunoz@neuroscienceconsultants.com](mailto:hmunoz@neuroscienceconsultants.com)
- K. If you wish to request a refill please have the pharmacy fax us the request at 305-596-0657 at least 72 hours in advanced.
- L. If you would like a copy of these policies please ask the clerk.
- M. Thank you for choosing our physicians.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

THANK YOU