PRECISION SPINE CENTER

REGISTRATION FORM

(Please Print)

Referring Physician:	
Referring Physician Phone:	**Primary Physician:**

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑Ms. ❑Miss	❑Dr.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:		phone no.: ( )	
P.O. box:		City:	State:	ZIP Code:	
Your Email:		Ethnicity ❑Hispanic ❑Non-Hispanic		Race	

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Internet ❑ Yellow Pages ❑ Other:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ AETNA ❑ Medicare ❑ Medicaid ❑ Blue Cross/Shield ❑ Cigna
❑ Workers Comp ❑ Self-Pay ❑United HealthCare ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Workers Comp.

Claim Number______________________________ **Case Manager** ______________________________

Case manager Phone: (___)___________________ **Case Manager Fax: (___)___________________**

Date of Injury_____________________________

Address: ____________________________________ **Workers Comp Claim Insurance Name:**____________________

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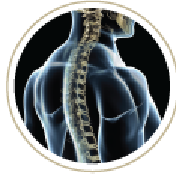
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Precision Spine Center or Insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*



Insurance Authorization

I have listed all health insurance plans from which I may receive benefits. I accept full responsibility to check with my insurance whether Neurosurgery Associates, LLC is in network prior to any appointments that I have. I hereby authorize payment of medical benefits billed to my insurance to Neurosurgery Associates LLC. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if Neurosurgery Associates, LLC does not participate with my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I, ________________________hereby authorize Neurosurgery Associates LLC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and health care operations. I understand that which this consent is voluntary, if I refuse to sign this consent, Neurosurgery Associates LLC can refuse to treat me.

I have been informed that Neurosurgery Associates LLC has prepared a notice that more fully describes that uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent. I understand that I may revoke this consent at any time by notifying Neurosurgery Associates LLC, in writing, but if I revoke my consent, such revocation will not affect any actions that Neurosurgery Associates LLC took before receiving my revocation.

I understand that Neurosurgery Associates LLC has reserved the right to change their privacy practices and that I can obtain such changed notice upon request. I understand that Neurosurgery Associates LLC does not have to agree to such restriction, but that once such restrictions understand that I have the right to request that Neurosurgery Associates LLC restrict how my individually identifiable health information is used/or disclosed to carry are agreed to, Neurosurgery Associates LLC must adhere to such restrictions.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Precision Spine Center or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date