

APPOINTMENT INFORMATION

Did a physician, PA, CNP or other provider send you to us for a consultation? Yes No If yes, name of physician, PA, CNP or other provider: _____ OR Did you make this appointment yourself: Yes No

Date of Accident/Injury: ____/____/____ OR Date Symptoms began: ____/____/____

Type of Accident: at work at home auto other (explain): _____

Name(s) of family, friends or others we may communicate with regarding your treatment, appointments, prescriptions, test results, billing and insurance questions, etc.: _____

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (M.I.) _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth ____/____/____ Social Security Number ____-____-____ Marital Status: _____

Home Phone (____) _____ Cell Phone (____) _____

Email Address: _____ Employer: _____

Work Phone (____) _____ Work Email Address: _____

Spouse's Name: _____ Employer: _____

Work Phone: (____) _____ Cell Phone (____) _____

Person to call in an emergency: _____ Relationship: _____

Home Phone: (____) _____ Cell Phone (____) _____

PERSONAL HEALTH INSURANCE INFORMATION

1st Insurance to be billed: _____ Policyholders Name: _____

DOB (Required if other than patient) _____ Effective Date of policy: Month _____ Year _____

Policy #: _____ Group #: _____ Employer: _____

Insurance Claims Address: _____

Phone Number: (____) _____ Patient's relationship to Policyholder: _____

2nd Insurance to be billed: _____ Policyholders Name: _____

DOB (Required if other than patient) _____ Effective Date of policy: Month _____ Year _____

Policy #: _____ Group #: _____ Employer: _____

Insurance Claims Address: _____

Phone Number: (____) _____ Patient's relationship to Policyholder: _____

MOTOR VEHICLE ACCIDENT (MVA) INSURANCE INFORMATION (If your appointment is the result of an MVA)

We do not bill third party motor vehicle insurance companies

Motor Vehicle Insurance: _____ Policy #: _____ Claim #: _____

Address: _____ Phone #: _____ Contact: _____

WORKER'S COMPENSATION INSURANCE INFORMATION If your appointment is the result of a work related injury or workmen's compensation claim, please complete the information below. Your visit to our office must be authorized by the worker's compensation insurance carrier or your employer prior to your appointment or we may be required to reschedule your appointment.

Employer when injured: _____ Phone #: (_____) _____

Address: _____ Contact Person: _____

Worker's Compensation Insurer: _____ Contact Person: _____

Address: _____ **Date of Injury:** _____

Phone #: (_____) _____ Claim #: _____ **State where Injured:** _____

Case Manager: _____ Phone #: (_____) _____

If you have retained the services of an attorney in connection with your injury or illness please give the attorney's name, address and phone number:

Attorney: _____ Phone #: (_____) _____

Address: _____

GUARANTOR OF PAYMENT (Please complete this section with parent or custodial information if the patient is a minor)

Name: (Last) _____ (First) _____ (M.I.) _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth ____/____/____ Social Security Number ____-____-____ Marital Status: _____

Home Phone (_____) _____ Cell Phone (_____) _____

Email Address: _____ Employer: _____

Work Phone (_____) _____ Work Email Address: _____

Spouse's Name: _____ Employer: _____

Work Phone: (_____) _____ Cell Phone (_____) _____

AUTHORIZATION AND CONSENT

I certify that the information I have furnished is complete, true and accurate.

Signed: _____ Date: _____

Acceptance of Financial Responsibility and Assignment of Benefits: I hereby authorize payment of benefits on my behalf under my insurance plan(s) and/or any government-sponsored plan(s) directly to Neurosurgical & Spinal Surgery Associates, P.C. and its divisions; Black Hills Neurosurgery & Spine, Neurology Associates, Promotion Physical Therapy and Electrodiagnostic Services (NSSA). I understand that if the providers of NSSA are not participating providers with my insurance plan(s) that I am responsible to NSSA for amounts determined ineligible by my insurance plan(s) due to their "maximum allowable", "usual, customary and reasonable" or other payment policies. I agree to pay any co-pays, deductibles or co-insurances that are my responsibility under my insurance plan(s). I understand that I will be billed and held responsible for my account regardless of the status of any insurance claim(s).

Signed: _____ Date: _____

Consent for Treatment: I hereby consent to such medical treatment, including evaluation, diagnosis, treatment or care, as ordered by my physician or other licensed provider for myself or for the patient for whom I am the parent or authorized representative. I acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment I receive.

Signed: _____ Date: _____

Authorization to Release Protected Health Information: I hereby authorize Neurosurgical & Spinal Surgery Associates, P.C. and its divisions to use or disclose my protected health information and/or other information to treat me, for requests by other health care providers involved in my continued or future treatment, to determine benefits, to authorize payment and to process claims for payment. I further request and authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information required to process my claim(s) or to provide continued or future treatment.

Signed: _____ Date: _____