Patient Information

Patent's Name (Last, First, MI) Sex Age Date of Birth

Address (street address/Apt #) City State Zip Code Home Phone No.

Cell Phone No. Email address

Social Security Number Status: Married Single Divorced Widowed Separated

Employer Occupation Employer's Address Employer's Phone Number

Responsible Party: Self Spouse Parent/Guardian Other_____
In case of emergency who should we contact?

Primary Insurance Information

Subscriber Name Relationship to Patient Birthdate Social Security Number

Address if different from patient Phone Number

Employer Employer's Address Employer's Phone Number

Insurance Company Name Insurance Company Address

Subscriber Number Group Number Insurance Co. Phone Number

Secondary Insurance Information

Subscriber Name Relationship to Patient Birthdate Social Security Number

Address if different from patient Phone Number

Employer Employer's Address Employer's Phone Number

Insurance Company Name Insurance Company Address

Subscriber Number Group Number Insurance Co. Phone Number

Please read all of the following and Acknowledge by Signing

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: I understand that I am responsible for all medical expenses of insurance coverage and whether or not there is an accident with another regardless person at fault. Payment is expected at the time of service unless prior arrangements have been made. I know that I am responsible for bringing my insurance card to the office.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Iredell NeuroSpine for the medical and/or surgical benefits of my insurance plan including Medicare. This payment guarantee will continue to be valid for any future visits to this practice.

AUTORIZATION FOR USE/DISCLOSURE OF INFORMATION: I understand that Iredell NeuroSpine may use my personal health information for the purposes of carrying out treatment, obtaining payment and evaluating the quality of services provided. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that other physicians involved in my care will be kept informed of my treatment. I hereby consent to the use and disclosure of my personal health information for the purposes noted in the Practice's Notice of Patient Information Practices. I understand that I have the right to revoke this authorization in writing, at any time be sending such written notice to the Practice Administrator at the address listed below.

CONSENT FOR EVALUATION AND TREATMENT: I hereby authorize Iredell NeuroSpine, their physicians, employees or agents to perform a physical examination and /or medical treatment deemed necessary by the treating physician. This includes, but not limited to any required medical examination, procedure or test ordered by the physician to be carried out by the designated staff.

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Signature of Patient, Parent or Guardian Date