Neurological & Spinal Surgery, L.L.C.

Patient Information Sheet

(PLEASE PRINT AND USE DARK INK)

PATIENT NAME First:_____ Middle Initial_____ Last:_____

Address_____ **CELL PHONE:** _____

City_____State_____ Zip_____ LANGUAGE (if other than English)_____

Age_____ Birthdate_____ Sex_____ Social Security (_____)-(_____)-(_____)

EMAIL_____ @_____

RACE: White_____ African American _____ Asian _____ Hispanic _____ Other_____

PATIENT EMPLOYER_____**WORK PHONE** _____

Spouse's Name_____His/Her employer_____

PRIMARY INSURANCE_____**NAME of POLICYHOLDER** _____

Phone ( )_____ ID #_____ Group #_____

Policyholder's S.S. _____-_____-_____ **Policyholder's BIRTHDATE**_____

SECONDARY INSURANCE_____**SUBSCRIBER/POLICYHOLDER** _____

Phone ( )_____ ID #_____ Group #_____

Policyholder's S.S. _____-_____-_____ **Policyholder's BIRTHDATE** _____

CONTACT PERSON:_____

Name Phone number Relationship

_____ **YES** ____**NO** I give the physicians/staff of NSS permission to discuss my medical information with this individual

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Neurological & Spinal Surgery, LLC in connection with medical services provided by Neurological & Spinal Surgery LLC, its employees and agents. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Should it become necessary to turn my account over to an outside collection agency, I will be responsible for collection costs, attorney fees, litigation fees, and court costs. I hereby authorize Neurological & Spinal Surgery, LLC and its employees and agents TO RELEASE ALL INFORMATION, reports, and records if necessary to secure the payment of my account, including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals, and doctors. If I have a liability injury, I understand that I have the option of using my health insurance, if available, or I will be expected to pay for treatment.

A copy of Neurological and Spinal Surgery's **Notice of Privacy Practice Policy**, which describes how health insurance information may be used or disclosed is available upon check in at my appointment or at **www.nssne.com**

My signature indicates the above information is correct to the best of my knowledge & that I understand and accept Assignment of Benefits, Neurological & Spinals Surgery LLC's Privacy Policy & authorize release of my medical information as outlined above.

Patient or Guarantor Signature:_____ **Date:**_____

OVER

Updated 01/30/2023