



Today's Date: / /

PATIENT INFORMATION					
Patient's Last Name			First	Middle	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid
Home Address:			Social Security Number:		Birth Date / /
					Age
					Sex <input type="checkbox"/> M <input type="checkbox"/> F
City	State	Zip	Home Phone: () -		Cell Phone: () -
Patient's Employer:			Employer Phone: () -		
Emergency Contact:			Phone: () -		Relationship to Patient:
Drivers License Number:			State:	Email Address:	
Referring Physician:			Primary Care Physician:		
Person Responsible for Bill:		Birth Date: / /	Address (if different):		Home Phone () -
Employer:		Employer Address:			Employer Phone () -

INSURANCE INFORMATION			
(Please give your insurance card and driver's license to the receptionist.)			
Primary Insurance:		Policy Number:	Group Number:
Subscriber's Name:		Subscriber's S.S. Number:	Birth date: / /
Patient's Relationship to Subscriber:		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Secondary Insurance (if applicable):		Policy Number:	Group Number:
Subscriber's Name:		Subscriber's S.S. Number:	Birth date: / /
Patient's Relationship to Subscriber:		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

2. I authorize my insurance carrier to release information regarding my coverage to Auburn Neurosurgery, PC. I also authorize agents of any hospital, or previous physicians to furnish Auburn Neurosurgery, PC copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state, or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Auburn Neurosurgery, PC.

3. My right to payment for pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Auburn Neurosurgery, PC. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to my or my representative, I will endorse such payment to Auburn Neurosurgery, PC.

4. I understand that my patient information arising out of my medical treatment by my physician practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payors; (b) governmental bodies (such as the FDA, and HCFA); (c) representatives and agents of my health benefit plan; (d) persons conducting quality or peer review or patient satisfaction surveys; and (e) other clinical and non-clinical parties that have a contractual relationship with Auburn Neurosurgery, PC.

5. **PERSONAL VALUABLES:** I acknowledge that Auburn Neurosurgery, PC shall not be liable for the loss or damages to any personal property.

6. **CONSENT FOR PHOTOGRAPH:** I, the undersigned, give Auburn Neurosurgery, PC, its physicians and staff, permission to make photographs of me for placement into my clinical record.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

I have read the above statements and accept the terms. A duplicate of the statement is considered the same as the original.

Patient Signature	Date
Responsible Party Signature	Date
Relationship to Patient	