PATIENT REGISTRATION – WESTERN NEUROSURGERY, LTD.

(PLEASE COMPLETE ALL FIELDS)

Patient Name (Full Legal Name): Last _____ First _____ Middle _____

Responsible Party (Parent, if minor): _____

Residing Address: _____ City, State, Zip: _____

Mailing Address: _____ City, State, Zip: _____

Home Phone: (_____) _____ Business Phone: (_____) _____ Cell Phone: (_____)_____

Sex: Female/Male Birthdate: _____/_____/_____ Social Sec #: _____-_____-_____

Visit Requested By:_____ If Physician: Address:_____Phone: (_____)_____
(First Name) (Last Name)

Primary Care Physician: _____ Address & Phone: _____
(First Name) (Last Name)

Marital Status: Single/Married/Widowed/Other Please Circle All That Apply: Employed Full-Time Student Part-time Student Unemployed

Patient's Employer/School: Name_____ Address: _____ Phone: (_____)_____

Spouse's Name: _____ Spouse's Employer:_____ Phone: (_____)_____

Nearest Relative Not Living with you (full name & phone number):_____ (_____) _____

Primary Insurance Co: _____	Secondary Insurance Co:_____
Insurance Address:_____	Insurance Address: _____
ID #:_____ Group/Claim #:_____	ID #:_____Group/Claim #:_____
Co-pay Amount: _____	Co-pay Amount: _____
Policy Holder Name: _____	Policy Holder Name: _____
Policy Holder's Date of Birth: _____/_____/_____	Policy Holder's Date of Birth: _____/_____/_____
Policy Holder's Sex: Female/Male	Policy Holder Sex: Female/Male
Relationship to Patient: (Self) (Spouse) (Child) (Other)	Relationship to Patient: (Self) (Spouse) (Child) (Other)
Policy Holder's Employer: _____	Policy Holder's Employer: _____
Policy Holder's Social Security #: _____-_____-_____	Policy Holder's Social Security #: _____-_____-_____

If this visit is related to a WORK related injury OR an AUTO accident please complete following information:

Industrial/Auto Insurance Carrier:_____ Address:_____

Telephone:_____ Claim No:_____ Adjuster's Name:_____

Date of Injury/MVA: _____

If Industrial Injury: Employer at Time of Injury: _____ Employer phone #:(_____)_____

Is case Open? (Please circle) Yes No Supportive Care Award: (Please circle) Yes No

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Release of Medical Records and Assignments of Benefits

I hereby authorize the Physicians of Western Neurosurgery, Ltd. to release any information acquired in the course of my examination or treatment to my insurance company, HMO, AHCCCS (AZ Health Care Cost Containment Systems) hospitals or referring Physician's office. I authorize assignment of benefits and payment directly to Western Neurosurgery, Ltd. and agree to pay any and all charges that exceed or that are not covered by insurance, including any attorney and collection fees incurred for collection purposes. Photocopy of this release and assignment is as valid as the original.

Signature: _____ Date: _____

If Signature is other than the patient's, relationship to patient: _____

WESTERN NEUROSURGERY, LTD.

Patient Privacy. Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy Practices in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been notified that the practice has such a Notice of Privacy Practices.

Print Name: _____

Signature _____ Date _____

Please list names of your spouse/significant other and/or children that can receive and/or discuss your medical information with us.

NAME/RELATIONSHIP	PHONE
_____	_____
_____	_____
_____	_____

This notice authorizes us to leave messages concerning appointments, lab results, etc. at the numbers you listed on your registration form. This also authorizes us to release information concerning your health to the names listed above.

Print Name: _____

Signature _____ Date _____

WESTERN NEUROSURGERY, LTD.
PATIENT RESPONSIBILITY POLICY:

PATIENTS ARE RESPONSIBLE **FOR CHECKING WITH THEIR CURRENT INSURANCE COMPANY** AS TO WHETHER OUR PHYSICIANS ARE CONTRACTED WITH THEIR INSURANCE PLAN. We do not contract with all insurance plans.

FEES: We must comply with insurance company regulations, consequently our fees are fixed. If your insurance DOES NOT PAY 100% of our contracted fees, you are responsible for your account balance prior to each visit. **If we are NOT contracted with your insurance plan, payment is expected at the time of service.**

COPAYS: All copays are collected when you arrive for your appointment. If you are not prepared to make your copay at the time of service, your appointment will be rescheduled.

SELF PAY: All visits to the doctor will require payment at the time services are rendered.

PATIENT'S BALANCE: ALL ACCOUNT BALANCES, AFTER INSURANCE HAS BEEN PROCESSED, WILL BE **DUE IN FULL WITHIN 30 DAYS**.

COLLECTIONS: Any patient that has been placed in **COLLECTIONS** must pay any prior balance owed to the practice as well as the collection agency fee **PRIOR** to being seen again in our practice.

PHARMACY INFORMATION:

Please provide your pharmacy information:

Your name: _____

Pharmacy Name: _____

Pharmacy phone number: _____ Fax: _____

Pharmacy address: _____

Prescription refills are provided only for medications prescribed by Western Neurosurgery physicians. If you need a refill, please call your pharmacy. If your prescription is a narcotic, please call our office 72 hours prior to running out of your prescription.

Patient Signature:_____

Date: _____

WESTERN NEUROSURGERY, LTD.

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, to promote the adoption of Meaningful Use of health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions and strengthen the civil and criminal enforcement of the HIPAA rules.

In order to comply with the above act, Western Neurosurgery, Ltd. is required to obtain specific documentation for your electronic medical record.

Please complete the following:

Your name:_____

RACE (please circle):

AMERICAN INDIAN/ALASKAN NATIVE
ASIAN
BLACK/AFRICAN AMERICAN
HISPANIC
NATIVE HAWAIIAN
OTHER PACIFIC ISLANDER
WHITE
OTHER