Neurospine Institute
Robert L. Masson, M.D., Mitchell L. Supler, M.D.
Patient Information Questionnaire

How did you learn about our practice? -

Physician Referring You To Our Practice:

Doctor Name - Dr. Vishal

Phone # - 7407405555

Address - sdfsadf

Primary Care Physician:

Doctor Name - Dr. Troy

Phone # - 4072840574

Address -

Patient Information:

Marital Status: - Single

Gender: - Male

Last Name: - PanchaTest

First Name: - VishalTest

Patient's Social Security #: - 3453455d

Date of Birth: - 2015-09-25

Home Phone #: - 3534555

Mobile Phone # - 34535345

Home Address: - 34535345

Apt #: - 1213

City: - ahmedabad

State: - 10

Zip: - 380051

Alternate Address: - addresss3dgdfgtt

Email Address: - vishal.panchal@bypt.in

Would you like to receive a monthly email newsletter - No

Employment Information

Employment Status: - Fulltime

Employer: - bypt

Occupation: - Sr. DeveloperrTod

Employer Address: - 208, dev castle, nr govindvadi bus stand, isanpur.

Primary Insured Person On Your Insurance (Guarantor):

Last Name: - Gupta

First Name: - Roman

Middle Name - 3435

Birthdate: - 2015-08-12

Social Security #: - 123456

Emergency Information: (Not living in the same household):

Please Notify (Name) - Rajesh

Phone # - 5405408989

Address - Vejalpur road

Relationship to patient - Father

Insurance Information

Is your visit today related to an auto accident? - No

Is your visit today related to a work injury? - No

Health Insurance Information: (Please provide card at time of visit)

Primary Insurance Co: - General Insurance

I.D.# - 123456

Grp # - Medical

Address: - Ellis bridge, Ahmedabad

Phone #: - 25398831

Secondary Insurance Co: - LIC Life Insurance

I.D.# - SASS

Group # - LIFE COVER

Address: - Relief road, Ahmedabad

Phone #: - 9889986666

Worker's Compensation Information

Insurance: - Bajaj

Claim #: - 9889986666

Claims Address: - Ashram road, Maninagar

Date of Injury: - 2009-03-10

Adjuster Name: - Vishal Panchal

Phone #: - 7407405555

Attorney Name: - Kishan Patel

Phone #: - 75075934

Auto Carrier Information

Insurance: - Relience Insurance

Claim #: - Mutiple

Claims Address: - S.G Highway, Ahmedabad

Date of Injury: - 2013-01-15

Adjuster Name: - Vishal Panchal

Phone #: - 435355

Attorney Name: - Sandeep Patel

Phone #: - 65765756767

Conditions of Treatment

Assignment of Insurance Benefits : In the event I am entitled to benefits or other recovery of any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, including but not limited to private and group health and hospitalization benefits, automobile liability, general liability, personal injury protection, medical payments and uninsured and underinsured medical benefits, such benefits or recovery are hereby assigned directly to the Neurospine Institute for application to the patient's bill, and I authorize direct payment to the Neurospine Institute of such benefits or recovery. I acknowledge that Section 817.234, Florida Statutes, provides that "any person who knowingly and with intent to injury, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

Authorization to Release Confidential Information: In the event I am entitled to benefits or other recovery of any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, including but not limited to private and group health and hospitalization benefits, automobile liability, general liability, personal injury protection, medical payments and uninsured and underinsured medical benefits, such benefits or recovery are hereby assigned directly to the Neurospine Institute for application to the patient's bill, and I authorize direct payment to the Neurospine Institute of such benefits or recovery. I acknowledge that Section 817.234, Florida Statutes, provides that "any person who knowingly and with intent to injury, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

I request that the Neurospine Institute withhold the following information from release:

I understand that if I do not authorize release of this information for the purpose of securing payment, I will be billed directly for the Neurospine Institute's charges. The authorization will remain in effect until the Neurospine Institute has been paid or settled, and may be revoked prior to that time, except to the extent that action has already been taken in reliance on it. Patients with implantable devices authorize the release of their Social Security number to the device manufacturer to comply with the Safe Medical Devices Act.

Patient/Guarantor Agreement: Whether I sign as agent/representative or patient, in consideration of the services to be rendered to patient, I hereby individually obligate myself to pay and unconditionally guarantee payment to the Neurospine Institute of patient's co-payments, deductibles and non-covered charges, in accordance with the regulate rates of the physicians of the Neurospine Institute or any of it's allied health staff, or such other rates and terms as are applicable to patient's account (s) by contract or regulation. Should any portions of the patient's account be referred to an attorney for collection, I agree to pay all expenses of collection, including reasonable attorney's fees, whether suit is filed or not. For purposes of this agreement, non-covered charges are those charges not covered by a third party payer for any reason.

Consent for Evaluation and Treatment: The patient hereby consents to any evaluation and treatment the assigned physician of the Institute may deem necessary to the patient named above.

Assignment of Medicare Benefits: Patient Certification, Authorization to Release Information. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to

the Social Security Administration or is intermediaries or carriers any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or the Neurospine Institute or authorize the physician or the Neurospine Institute to submit a claim to Medicare for payment to me. I understand that I am responsible for any applicable deductible and co-insurance, and non-covered services, including personal charges.

Execution of my signature below authorizes and agrees with all conditions above:

Signature of Patient - xxxx xxx xxx xxx
Date - xx xx xxxx

Signature of Parent, Guardian, and/or Responsible Party - xxxx xxx xxx xxx
Date - xx xx xxxx

Neurospine Institute
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Patient Information-Privacy Notice

WRITTEN ACKNOWLEDGEMENT OF PATIENT OR PERSONAL REPRESENTATIVE OF PATIENT THAT THEY HAVE READ NEUROSPINE INSTITUTE'S PRIVACY PRACTICE PROVIDED VIA WEBSITE OR PHYSICAL ADDRESS LISTED BELOW:

Signature of Patient/Personal Representative
Social Security Number - xx xx xxxx
Date - xx xx xxxx

REQUESTS FOR COPIES OF THE NEUROSPINE INSTITUTE PRIVACY PRACTICE CAN BE MADE IN WRITING TO THE FOLLOWING ADDRESS:

Neurospine Institute
2706 Rew Circle, Ste 200,
Ocoee, Florida 34761