NeuroSpine
GET YOUR LIFE BACK™

<table>
<tr><td rowspan="7">Patient Information</td><td colspan="5">Name (Last, First MI)</td><td colspan="3">Today's Date</td></tr>
<tr><td colspan="5">Street Address</td><td>City</td><td>State</td><td>Zip</td></tr>
<tr><td colspan="5">Mailing Address</td><td>City</td><td>State</td><td>Zip</td></tr>
<tr><td colspan="3">Home Phone ☐ Preferred ( )</td><td colspan="3">Work Phone ☐ Preferred ( )</td><td colspan="2">Cell Phone ☐ Preferred ( )</td></tr>
<tr><td colspan="2">SSN</td><td colspan="2">Date of Birth</td><td colspan="2">Gender ☐ Male ☐ Female</td><td colspan="2">Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated</td></tr>
<tr><td colspan="2">Pharmacy Preference</td><td colspan="2">Pharmacy Phone</td><td colspan="2">Preferred Language</td><td colspan="2">Email Address</td></tr>
</table>

Financially Responsible Party	Is the patient a responsible party/guarantor? ☐ Yes ☐ No (If you are over the age of 18 and not in the care of an institution, you are the guarantor, as you are the person financially responsible for any charges you may incur during your visit)

	Name	Address	City/State/Zip	Relationship to Patient
	Occupation	Employer	Email Address	Date of Birth
	Home Phone ☐ Preferred ( )	Work Phone ☐ Preferred ( )	Cell Phone ☐ Preferred ( )	

Emergency Contact	Name	Relationship to Patient
	Home Phone ☐ Preferred ( )	Work Phone ☐ Preferred ( ) Cell Phone ☐ Preferred ( )

Referral Info	Referring Physician's Name	Physician Phone/Fax (if known) ( )
	Physician Address	

PCP Info	Primary Care Physician's Name (Check if same as Referring Physician above ☐)	Physician Phone/Fax (if known) ( )
	Physician Address	

Insurance Information

Primary Insurance Company		Policy #	Group #
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____		Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	Employer of Subscriber	Work Phone ( )

Secondary Insurance Company		Policy #	Group #
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____		Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	Employer of Subscriber	Work Phone ( )

Injury/Accident Information	□ Workers' Compensation □ Auto Accident □ Other	Employer (if WC)	Date of Injury	Did Injury Occur in Oregon? □ Yes □ No If no, which state?
	Insurance Company		Policy Number	Claim Number
	Description of Injury (activity, body part, etc.)			
	Are you represented by an attorney for this injury? □ Yes □ No		Name of Attorney	
	Address		Phone ( )	Fax ( )

ASSIGNMENT OF BENEFITS AND
ACKNOWLEDGEMENT THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES

1. I hereby assign to NeuroSpine Group, LLC, all money (not to exceed my indebtedness) to which I am entitled for medical or surgical expenses for such charges incurred with NeuroSpine Group, LLC, on my behalf or at my request.
2. I understand that I may be responsible for the payment of the bill regardless of whether the charges may be covered by insurance or the other party's responsibility. This includes supplies that I may receive that are not covered by insurance.
3. I hereby authorize insurance to release information regarding any claim, assigned or unassigned, to NeuroSpine Group, LLC.
4. If NeuroSpine Group, LLC, engages an attorney to collect the fees and charges owed, I will pay the reasonable attorney fees incurred by NeuroSpine Group, LLC, in any suit, action, or subsequent appeal.
5. I understand my email address will be used to send educational information, practice updates, and invitations to participate in an online patient portal. Each email contains a link to opt out of receiving future communication if I so choose.
6. By signing below, I acknowledge that the information I provided is correct to the best of my ability.

_____   _____

Signature (Parent / Legal Representative)   Date

_____   _____

Printed Name   Relationship to Patient

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