

# OCALA NEUROSURGICAL CENTER, INC.

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## PATIENT INFORMATION

(Please Print Clearly)

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  
(Last) (First) (Middle Initial)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex \_\_\_\_ M \_\_\_\_ F Marital Status \_\_\_\_\_ Spouse Name \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ S.S.# \_\_\_\_\_

Driver's License Number \_\_\_\_\_ Referring Doctor \_\_\_\_\_

Name of Employer \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_

Person **Who Does Not Live With You** To Contact In Case Of An Emergency: (Not Spouse)

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship To Patient \_\_\_\_\_

## EMPLOYER GROUP/COMMERCIAL INSURANCE

If you do not have medical insurance check and initial here  \_\_\_\_\_

**#1 Insurance Company Name** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_ Policy Number \_\_\_\_\_ Group # \_\_\_\_\_

Insured (if different from patient) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Social Security Number \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Insured's Employer \_\_\_\_\_

### If Champus:

Subscriber Number \_\_\_\_\_

Branch of Service \_\_\_\_\_

Status: Active \_\_\_\_ Retired \_\_\_\_ Deceased \_\_\_\_

**#2 Secondary Insurance Company Name** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber (if different from patient) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber's Social Security Number \_\_\_\_\_ Subscriber's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

If Medicare: Medicare Number \_\_\_\_\_ If Medicaid: Medicaid Number \_\_\_\_\_

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. RELEASE OF INFORMATION - I, the below named patient, to hereby authorize any physician examining and/or treating me to release any third payor (such as an Insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its Intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

V. THIS OFFICE IS NOT RESPONSIBLE FOR ANY DISSEMINATION OR DISCLOSURE OF YOUR CONFIDENTIAL MEDICAL INFORMATION ONCE WE PROVIDE SUCH INFORMATION, AT YOUR REQUEST, TO YOUR HEALTH INSURER OR EMPLOYER.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payor within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

DATE \_\_\_\_\_ PATIENT \_\_\_\_\_  
Signature

SUBSCRIBER (if different from patient) \_\_\_\_\_ RESPONSIBLE PARTY \_\_\_\_\_  
Signature Signature