LANCASTER
NEUROSCIENCE
& SPINE ASSOCIATES
THE CENTER FOR SPINE CARE

PATIENT DEMOGRAPHICS

DATE _____

NAME _____ SOCIAL SECURITY # _____
ADDRESS _____ DATE OF BIRTH _____
CITY _____ STATE _____ ZIP _____ HOME PHONE _____
REFERRING PHYSICIAN _____ WORK PHONE _____
ADDRESS _____ CELL PHONE _____
FAMILY PHYSICIAN _____ SEX: MALE FEMALE
ADDRESS _____ STUDENT: FULL-TIME PART-TIME NA
EMERGENCY CONTACT _____ MARITAL STATUS: MARRIED SINGLE
RELATIONSHIP _____ HOME PHONE _____ WORK PHONE _____ OTHER _____

PATIENT CURRENT EMPLOYER _____ PHONE _____
ADDRESS _____ FAX# _____
CITY _____ STATE _____ ZIP _____

FIRST INSURANCE _____ INSURANCE CO. PHONE _____
ADDRESS _____ FAX # _____
CITY _____ STATE _____ ZIP _____ GROUP # _____
INSURED'S NAME _____ DATE OF BIRTH _____ POLICY # _____
INSURED'S EMPLOYER _____ SOCIAL SECURITY # _____

SECOND INSURANCE _____ INSURANCE CO. PHONE _____
ADDRESS _____ FAX # _____
CITY _____ STATE _____ ZIP _____ GROUP # _____
INSURED'S NAME _____ DATE OF BIRTH _____ POLICY # _____
INSURED'S EMPLOYER _____ SOCIAL SECURITY # _____

WORKER'S COMPENSATION INJURY YES NO BODY PART INJURED _____ DATE OF INJURY _____
EMPLOYER AT TIME OF INJURY _____ CLAIM # _____
INSURANCE COMPANY _____ INS. CO. TEL. # _____
ADDRESS _____ FAX# _____
CITY _____ STATE _____ ZIP _____ DATE OFF WORK _____
ADJUSTER _____ CURRENTLY WORKING? _____

AUTOMOBILE INJURY YES NO
INSURANCE COMPANY _____ DATE OF INJURY _____
ADDRESS _____ STATE _____
CITY _____ STATE _____ ZIP _____ CLAIM/POLICY # _____
ADJUSTER _____ INS. CO. TEL. # _____
POLICY HOLDER _____ FAX# _____

PLEASE CONTINUE AND COMPLETE PAGE 2

CONSENT TO TREATMENT, RELEASE AND ACKNOWLEDGEMENT FORM

CONSENT TO TREATMENT **PATIENT MRN: _____**

I request those physicians and other healthcare professionals who care for me to perform routine examinations, diagnostic procedures, hospital care and therapeutic treatments, which in their judgment become necessary while I am a patient of the Physician Practice. Routine diagnostic procedures and medical treatments include but are not limited to EMG/NCVs, Discograms, physical therapy, and administration of medications.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examination. I, understand that the Physician Practice, in order to deliver quality healthcare, develops and maintains health information which may include physician notes, history and physical, medication reports, tests and test results, and treatment plans. I concur that this health information is used for the following:

- o care and treatment plans
- o billing statements
- o communication between interdisciplinary healthcare providers
- o verification of services by third party payers and government payers
- o quality control by the Physician Practice

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Physician Practice for any services furnished to me by that provider of service. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

STATEMENT TO PERMIT PAYMENT OF MEDICAID BENEFITS TO PROVIDER AND PHYSICIAN

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Department of Public Welfare (DPW) or its intermediaries or carriers any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to DPW for payment.

ASSIGNMENT OF INSURANCE OR PAYOR BENEFITS

I recognize that I am primarily liable for payment for services rendered, however, in the event that I am entitled to medical care benefits of any type whatsoever, I hereby assign those benefits to the Physician Practice and any of its contracted health care providers. I authorize the Physician Practice and the appropriate health care providers to apply for benefits on my behalf for services rendered during this admission or visit. I certify that the insurance or other coverage benefit information supplied by me is correct, in accordance with applicable Physician Practice, provider or insurance policies or agreements. If my insurance carrier requires pre-authorization for services I receive, I understand that it is my responsibility to contact my personnel office and/or insurance carrier to obtain it. If I fail to do so, I could be liable for all or part of otherwise covered expenses.

COMMUNICATION AUTHORIZATION

I authorize the Physician Practice, physicians and other health care providers to use telephone message systems to aid communication with me, or my authorized representative(s), regarding my treatment, appointments, financial arrangements, and in response to any request I may have initiated.

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I authorize the Physician Practice, physicians and other health care providers to share information and provide copies of my medical record including all written and oral reports, substantive evaluations of progress, history, diagnosis, prognosis, course of treatment, reports and attendance and compliance with respect to all care of treatment to my insurance carrier, physicians, treating facilities and the following individuals:

_____ Spouse - Name _____ _____ Parents if over 18 - Name(s) _____

_____ Children - Name(s) _____

_____ Authorized Representative(s) - Name _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Physician Practice's Notice of Privacy Practices. I understand that information the Physician Practice acquires or creates about me will only be disclosed to others for treatment, payment and health care operations as set forth in the Notice of Privacy Practices or as authorized by me in writing.

I CERTIFY THAT I HAVE READ THIS FORM AND THAT I UNDERSTAND ITS CONTENTS.

_____ _____

Signature Witness

_____ _____ Patient _____ Substitute Decision Maker

PRINTED NAME

_____ Date Completed If Substitute Decision Maker, state relationship_____