PATIENT INFORMATION FORM

1. PATIENT INFORMATION ACCT#

Name**:** Date of Birth:

Street Address Social Security Number:

City: State: Zip: Home Phone:

Work Phone: Cell Phone:

Sex: Marital Status: Spouse Name:

Spouse Work Phone: Cell Phone :

Referred By: Primary Care Physician:

2.GUARANTOR(RESPONSIBLE PERSON) INFORMATION

Name: Date of Birth**:** SS**#**

Street Address:

City: State: Zip:

Home Phone:

Cell phone: E-mail address_____

Employer: Phone:

Address: City: State**:** Zip:

3. HEALTH INSURANCE INFORMATION

PRIMARY: ID#: Group #:

Name of Insured**:** Insured's relationship to patient:

SECONDARY: ID: Group **#:**

Name of Insured: Insured's relationship to patient:

Name:

Which Pharmacy do you prefer us to call in prescriptions?

Name: **Phone( )**

City:

4.EMERGENCY CONTACT INFORMATION

Name: Relationship: Daytime phone: Cell phone

Address: City: State: Zip:

5. AUTHORIZATION

Initial	I understand that many procedures performed by Comprehensive Spine & Neurosurgery Services, Inc. ("CSNS") are highly specialized and demand extensive education and training. I also understand that the fees for services provided by CSNS may exceed the amount paid by my insurance company. I agree to pay CSNS the contractually agreed upon co-insurance, deductible, or eligible charge as determined by the contract CSNS currently has with my insurance carrier. In those situations wherein CSNS is not a contracting provider with my insurance company, I understand that I must pay that portion, if any, of my bill that is not covered by my health insurance. I understand that by signing this agreement as patient or as agent, I obligate myself to pay my account in full. Should the account be referred for collection, the undersigned shall pay reasonable attorney fees and cost of collection. All delinquent accounts bear interest at the legal rate. I understand that CSNS has no obligation to prepare consultation reports and/or narrative reports for any attorney or appear at any deposition. I also understand that CSNS has no obligation to appear as an expert witness in court on my behalf.
Initial	I hereby authorize use of this form on all my insurance submissions. I hereby authorize release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment direct to my doctor.
Initial	**Release of Protected Health Care** information via telephone or answering machine or voice mail. I give my consent with authorization to the medical and billing staff of my physician office to leave protected health care information about me or for me on my answering machine or voice mail via the telephone # I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office. Home Telephone # _____ Cell phone # _____
Initial	I permit a copy of this authorization to be used in place of the original.
Initial	I hereby authorize the treating person(s) to take photographic pictures of the treated areas and I understand that these pictures will be safely stored in the named patient's clinical record.
Initial	As required by the Privacy Regulations, I hereby acknowledge that I have reviewed a current copy of "Notice of Privacy Policy". I have read the Privacy Policy and understand my rights contained in the notice.
Initial	By way of my signature, I provide CSNS, Inc. my authorization and consent to use and disclose protected healthcare information for the purposes of treatment, payment and healthcare operations described in the Privacy Policy.

Signature_____Date_____

Printed Name _____Relationship to Patient_____

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean Name

"Physician" shall be understood to mean «USName» and Columbus Spine & Neurosurgery Services Inc.

Further, I understand that I am entering into a contractual relationship with the physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and my result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the physician, I «PFirst» «PInit» «PLast» and/or my representative agree not to initiate or advance, directly or indirectly any meritless or frivolous claim (s) of medical malpractice against the Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I «PFirst» «PInit» «PLast» and/or my representative agree to use American Board of Medical Specialties (ABMS) board-certified expert medical witness (es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Board of Neurological Surgeons.

In further consideration for this, Physician agrees to the same stipulations.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

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NO SHOW POLICY

Effective Date: December 1, 2008

It is the policy of this office to request patients to give 24 hours notice if unable to keep appointment.

Missed appointments are referred to as "no show". No show will be documented in the patient's chart and on the scheduling module. After two no shows, the patient will be informed by letter that they are dismissed from the practice unless their absence was due to an emergency or death in the family. There will be a $25.00 charge for no show appointment.

A new patient who "no shows" 2 times in succession will not be rescheduled. A letter will be sent to the referring physician about our no show policy.

By notifying us that you are unable to keep your appointment, we will be able to offer this appointment time to another patient that is in need.

Thank you for your cooperation in this matter.

Please sign below to acknowledge you have read and understand this policy.

_____ Date: _____

COMPREHENSIVE SPINE & NEUROSURGERY SERVICES INC.
PATIENT CARE AGREEMENT

Please initial by each bullet point and sign at the bottom of this agreement

As a patient of Comprehensive Spine & Neurosurgery Services, I agree to the following:

_____1. I will provide complete information about my illness/problem, medications, and health habits to enable proper evaluation and treatment.

_____2. I will read and keep the resources I am provided so that I have an understanding of my condition or problem, and to use the resources provided to avoid unnecessary visits or phone calls.

_____3. I, and others who accompany me to appointments or call on my behalf, will show respect to office personnel and other patients. Lack of such may lead to dismissal from the practice.

_____4. I will have tests done in a timely manner as directed by the provider.

_____5. I will pay co-pays or bills in a timely manner and agree that failure to do so my result in dismissal from the practice.

_____6. I will use prescriptions or other medical devices prescribed according to directions.

_____7. I will accept responsibility for my actions including misuse of drugs, (whether illicit or prescription) tobacco, alcohol, or activities.

_____8. I will follow the guidelines set for any limitations in work, activity, or diet.

_____9. If I decide to leave outpatient or inpatient treatment against medical advice (leave CSNS), I may be dismissed from the practice.

_____10. If I have pending litigation against a medical provider, I may be dismissed from the practice.

Patient Signature: _____ Date: _____