CarePoint HEALTHCARE

************PLEASE FILL OUT FORM COMPLETELY. WE WILL NOT BILL YOUR INSURANCE IF FORM IS INCOMPLETE************

Patient's First _____ **MI**_____ **Last** _____

Mailing Address _____

City _____ **State**_____ **Zip**_____

Home Phone Number (_____) _____-_____ **Cell Phone Number** (_____) _____-_____

Email: _____

Date of Birth _____/_____/_____ **(mm/dd/yyyy) Social Security Number**(SSN) _____-_____-_____

******If patient is a minor, please supply guarantor information to the front desk******

*******Does your insurance require a formal referral from your PCP to a specialist for office visits? Yes ☐ No ☐**

If yes, please make sure we have a current copy of the referral (authorization) or you may be responsible for the cost of the visit.

Primary Care Physician (PCP) _____ **Phone #:**_____

Physician who referred you to our practice_____ **Phone #:**_____

Primary Insurance (Must be completed even if we copy your card):

******Copayments are due on the date of service – required by managed care contract******

Name of Insurance Company _____ **ID #** _____

Insured Name: _____ **Date of Birth** ____/____/_____ **Relationship to Patient: ☐ Self ☐ Spouse ☐ Other**

Secondary / Other Insurance (Please see below if Medicare is secondary)

Name of Insurance Company _____ **ID #** _____

Insured Name: _____ **Date of Birth** ____/____/_____**Relationship to Patient:** ☐ Self ☐ Spouse ☐ Other

*******NOTE: If Medicare is your secondary insurance, we are required to give the reason when we file claims:**

_____ Working Aged Beneficiary or spouse with Employer Group Health Plan
_____ Disabled Beneficiary under age 65 with Group Health Plan
_____ No-fault Insurance including Auto is Primary
_____ Veteran's Administration
_____ Worker's Compensation is Primary
_____ Other Liability Insurance is Primary

****Is this visit accident related? yes ☐ no ☐ If yes, is it billed to: Auto ☐ WorkComp ☐ Other ☐** _____

Date of Injury _____/_____/_____. **(Must have mm/dd/yyyy) Claim number for WC / Auto** _____

******If Auto, you must supply proof of medical payments on your policy**

*****If work comp injury, you MUST provide claim number and adjuster name and phone number along with employer info below *******

Adjustor/Caseworker/ Name and phone # _____

Emergency Contact Person:

Name_____**Phone(**_____**)**_____ **Relationship**_____

Pharmacy Preference (include location) _____**Phone#:**_____

Authorization: I hereby authorize release of information necessary to file a claim on my behalf with CMS and its agents (Medicare) and all other insurance carriers. I authorize CarePoint Neurosurgery to appeal on my behalf, any insurance carrier's payment or decision.

Assignment: I hereby assign medical benefits otherwise payable to me to CarePoint Neurosurgery. I understand and agree I am financially responsible for any unpaid balance for services rendered along with legal fees incurred in collecting payment from me. If applicable, I understand I am responsible for all copays, deductibles, co-insurance and balances.

Release: I hereby consent to the release of information provided to, or generated by CarePoint Neurosurgery, to my primary care physician, referring physician, psychologist, attorney, therapist, agency or any other party with a bonafide, pertinent interest, via verbal, written, or fax/e-mail communication. A copy or scanned image of my signature shall be as valid as the original.

_____ _____

Signature of Patient, Parent (if Patient is Minor), or Legal Guardian **Date**