

PATIENT INFORMATION

Last Name		First	Middle Initial	
Street Address		City	State	Zip
Home Phone with Area Code	Work/Other Phone with Area Code	Today's Physician		Referring Physician
Social Security #		Emergency Contact with Phone Number		
Employer			Employer Address	
Sex	Date of Birth	Marital Status S M W D Sep	Primary Care Physician (PCP)	
Work Accident/Injury?	Auto Accident/Injury?	If so, date of accident/injury and state.		

INDIVIDUAL RESPONSIBLE FOR PAYMENT – IF OTHER THAN THE PATIENT

Last Name		First	Middle Initial	Date of Birth
Street Address		City	State	Zip
Home Phone with Area Code	Work/Other Phone with Area Code	Social Security #		
Employer		Employer Address		

PRIMARY INSURANCE COMPANY

Insurance Name		Policy ID #	Group #
Street Address		City	State Zip
Name of Policy Holder		DOB of Policy Holder	Relation To Insured

SECONDARY INSURANCE COMPANY

Insurance Name		Policy ID #	Group #
Street Address		City	State Zip
Name of Policy Holder		DOB of Policy Holder	Relation To Insured

ADDITIONAL INFORMATION – OFFICE USE ONLY

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to *The Kansas City Neurosurgery Group, LLC*, for services rendered. I understand I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. If my insurance requires a referral/authorization from my Primary Care physician, I understand it is my responsibility to obtain it. Should my Primary Care physician fail or refuse to provide a referral/authorization, I understand I will be responsible for full payment of charges for services rendered to me by *The Kansas City Neurosurgery Group, LLC*, payable at the time of service. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits; and agree a photocopy of this agreement shall be as valid as the original. No guarantees have been made to me regarding the outcome of this care. It is understood and agreed the physicians of *The Kansas City Neurosurgery Group, LLC*, have the right to offer one of their associates to provide care in the absence of my doctor.

Date _____

Your Signature _____