



ADULT Registration Forms
Please – Complete the ENTIRE FORM.

Date: _____

Checked-in: _____

Updated: _____

Patient's Name _____
(Last) (First) (MI)

Address _____
(Street) (City) (State) (Zip)

Home Phone () _____ Work Phone () _____ Ext. _____

Cell Phone () _____ E-mail address: _____

Age _____ Date of Birth _____

Social Security # _____ Marital Status: _____ Sex _____

Employer/School _____

Address _____
(Street) (City) (State) (Zip)

Spouse's Name _____ Date of Birth _____

Social Security # _____ Spouse's Employer _____

Phone # () _____

Referring Physician _____
(The physician who requested your consultation with our office)

Family Physician _____
(If different than the Referring Physician)

Nearest relative or friend, not living with you that we may contact in case of emergency or if we need to change an appointment and cannot reach you?

Name _____ Relationship _____



Phone _____

Patient Name: _____

Who is Financially Responsible?

HEALTH INSURANCE INFORMATION

Primary Insurance Carrier Name _____ Copay \$ _____

Policy # _____ Group # _____ Policyholder _____

Secondary Insurance Carrier Name _____ Copay \$ _____

Policy # _____ Group # _____ Policyholder _____

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Auto Insurance Name (if due to an accident) _____

Name of Policy Holder _____ Claim # _____

Address of Insurance Company _____ City _____ State _____ Zip _____

Phone # () _____ Accident Date _____

Name of person handling claim _____

Do you have an attorney or legal action current or pending for the condition for which you are seeking legal consultation? _____

- If so, name of attorney _____ Attorney phone #: _____

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Work Comp Information (if applicable):

Name of Work Comp Carrier _____

Address _____ City _____ State _____ Zip _____

Claim # _____ Name of Person Handling Claim _____

Phone # () _____ Ext. # _____ Fax # () _____

Date of Injury _____ Case Manager _____

Do you have an attorney or legal action current or pending for the condition for which you are seeking legal consultation? _____

- If so, name of attorney _____ Attorney phone #: _____

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Self-Pay: Please read & sign our **Financial Policies** & ask to meet with a **Financial**

Counselor within our office. ***This is required prior to your clinic visit.***



Patient Name: _____

I hereby authorize MIDWEST NEUROSURGERY, P.C. to furnish third party payors with any information concerning the medical care, treatment and billings.

I hereby assign to MIDWEST NEUROSURGERY, P.C. all payments for medical services to be rendered to me or my dependents, and I authorize direct payment for such benefits to MIDWEST NEUROSURGERY, P.C. by any third party payor. I understand that I am responsible for all medical fees and costs regardless of the insurance coverage and that Medicare and insurance plans require that all co-pays and deductibles be collected. To the extent there is multiple coverage by third party payors such benefits shall be coordinated and the collection of any deductibles, co-insurance or co-payments up to the full amount of the account balance shall be permitted, and I shall remain responsible for the said amount. I agree to pay a late charge at the rate of 1 1/3 percent per month on any amounts due from and after the 31st day following the invoice date until paid in full if there is no applicable insurance coverage. If a claim is pending with a third party payor, no interest shall accrue until such time as the third party payor denies all or part of the claim, in which case I agree to pay a late charge at the rate of 1 1/3 percent per month on any unpaid amounts from and after the 31st day following the date MIDWEST NEUROSURGERY, P.C. or I receive notice of the same, whichever is earlier. I also agree that if any dispute arises between MIDWEST NEUROSURGERY, P.C. and me, the laws of the State of Nebraska shall govern, and all disputes between MIDWEST NEUROSURGERY, P.C. and me must only be litigated in the appropriate court in Douglas County, Nebraska, and I consent to personal jurisdiction and venue being proper in the appropriate court located in Douglas County, Nebraska.

Patient or Guarantor Signature

Date