HEARTLAND NEUROSURGERY

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PATIENT INFORMATION

Last Name	First	Middle Initial	Social Security Number	
Street Address	City	State Zip	Gender ☐ M ☐ F	Date of Birth
Home Phone (with area code)	Work/Other Phone (with area code)	Email Address		
Marital Status ☐ S ☐ M ☐ W ☐ D ☐ Sep	Emergency Contact	Relationship	Phone Number	
Employer	Employer Address			
Today's Physician	Referring Physician with Phone Number	Primary Care Physician with Phone Number		

Is your condition related to: ☐ Work-Related Accident? ☐ Auto Accident? ☐ Other Accident?

If so, date of accident/injury and state:_____

If employment related, has a workers' compensation claim been filed? ☐ Yes ☐ No

If auto accident, please list claim #:_____

INDIVIDUAL RESPONSIBLE FOR PAYMENT – If Other Than Patient

Last Name	First	Middle Initial	Relationship
Street Address	City	State	Zip
Home Phone (with area code)	Work/Other Phone (with area code)	Date of Birth	
Employer	Employer Address		

INSURANCE INFORMATION

PRIMARY Insurance Company	Policy ID #	Group #
Street Address	City	State Zip
Name of Policy Holder	DOB of Policy Holder	Relationship to Insured
SECONDARY Insurance Company	Policy ID #	Group #
Street Address	City	State Zip
Name of Policy Holder	DOB of Policy Holder	Relationship to Insured

Assignment of Benefits – Financial Agreement: I hereby give lifetime authorization for payment of insurance benefits to be made directly to Neurosurgery of South Kansas City, 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 that 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 Neurosurgery of South Kansas City, LLC, payable at the time of services. I hereby authorize this healthcare provider to release all information necessary to secure 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 that the physicians of Neurosurgery of South Kansas City, LLC have the right to offer one of their associates to provide care in the absence of my doctor.

Date:_____ Patient/Guardian Signature:_____