PARKWAY NEUROSCIENCE AND SPINE INSTITUTE, LLC
PATIENT REGISTRATION AND INFORMATION

Patient Information **Today's Date:** ________________

Last Name_________________________________ First Name_________________________ M.I._______
Date of Birth _____/______/______ Age_______ Social Security #______________________________
Address ____
Apartment or Room__________City___________________________State_____Zip_________________
Home# (___)____________________Work# (___)____________________Ext__________
Cell# (___)______________________Email ___________________________

(Please circle above preferred method of contact)

Sex (circle): Male Female Employer______________________ Email: _________________________
Marital Status (circle): Married Single Widow(er) Divorced Separated
Race (check one): ___ American Indian ___ Asian ___Black/African American ___Native Hawaiian
___ Other Pacific Islander ___White ___Prefer not to answer
Ethnicity (check one): ___ Hispanic/Latino ___Not Hispanic ___Prefer not to answer
Preferred Language (check one): ___ English ___Spanish ___Other _______(list) ___Prefer not to answer

Referring Doctor ___________________________________Office Phone #(___)____________________
Address ____
Primary Care Physician______________________________ Office Phone #(___)____________________
Address ____

Emergency Contact

Name_____________________________ Relationship________________ Phone(___)_______________

Do you give our office permission to discuss your medical information with family members? Yes No

If yes, please provide their name and phone number below.

Name: ____ Phone (_____) _________________________
Name: ____ Phone (_____) _________________________
May we leave personal medical information on your voice mail? Yes No
May we email personal medical information to you? Yes No
May we email updates, newsletters and general PNSI information to you? Yes No

How did you hear about PNSI? (circle) Ad Flyer Web Friend/Family Family/Referring Physician

Insurance Information

Note - If you have a worker's compensation or auto claim, please also fill in your health insurance information

Section A- Medicare/Medicaid

Do you have Medicare? Yes No If yes, Medicare #______________________
Effective date: ____________ Is Medicare your primary or secondary insurance? Primary Secondary
Do you have Medical Assistance (Medicaid)? Yes No If yes, Medicaid #______________________
Effective date____________ Is Medicaid your primary or secondary insurance? Primary Secondary
Do you have any supplemental insurance? Yes No Insurance__________________________________
ID#_________________________________ Is this primary or secondary? Primary Secondary

Patient Name: ______________________________

Insurance Information continued

Section B- Health Insurance

Insurance Company__________________________________ Referral Required (circle) Yes No
ID #____ Group__________________________
Insurance Subscriber_________________________________ Date of Birth _______/_____/______
Relationship to Patient_______________________________ Social Security #_________________
Subscriber Employer_________________________________ Work # (___)____________________
Employer Address____
Do you have a secondary insurance? Yes No Insurance Company______________________________
ID #____ Group__________________________
Insurance Subscriber_________________________________ Date of Birth _______/_____/______
Relationship to Patient_______________________________ Social Security #_________________
Subscriber Employer_________________________________ Work # (___)____________________
Employer Address____

Section C- Automotive Accident Liability Information

Is this injury related to a motor vehicle accident? Yes No If yes, Date of Accident_____/_____/______
Auto Insurance Carrier__________________________Claim #___________________________________
Claims Address____ Phone # (___)___________________

****Note – For Automotive Accident claims - If you DO NOT have health insurance you will be responsible for the payment in full at the time of service.***

Section D- Worker's Compensation Claim Information

Is this injury related to a work accident? Yes No If yes, Date of Accident_____/_____/______
Compensation Insurance___________________________Claim #__________________________________
Claims Address____ Phone # (___)___________________
Claim Adjuster____ Employer's Name__________________

I, the below signed, certify that the above information is true and correct to the best of my knowledge.

Signature of Patient/Responsible Party:_____________________________Date: _________________________

Cancellation Policy

Parkway Neuroscience and Spine Institute, LLC requires 24 hour notice when canceling any appointment. I understand that I will be liable for a charge of $40.00 if I fail to give such notice to cancel a medical appointment, physical therapy appointment or chiropractic appointment and a $100.00 charge for a procedure/surgical appointment. After three charges/violations you may be subject to termination from PNSI.

Return Check Policy

Parkway Neuroscience and Spine Institute, LLC charges $35.00 for all returned checks.

I, the below signed, understand and agree to the terms of the previous information.

Signature of Patient/Responsible Party:_____________________________Date: _________________________

PARKWAY NEUROSCIENCE AND SPINE INSTITUTE, LLC
AUTHORIZATION/ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I ____ (Print Name) hereby authorize benefits to be assigned to Parkway Neuroscience and Spine Institute, LLC, ("Provider"), for healthcare services provided to me by Provider. I hereby certify that the insurance information that I have provided Provider is true and accurate as of the date of service and that I am responsible for keeping it updated at all times. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I am responsible for payment of any and all amounts not paid by my insurance company due upon receipt of invoice or statement from Provider, including for any services which my insurance company has determined not to be covered by my policy.

I hereby authorize Provider to submit claims on my behalf to the insurance company listed on the copy of the current insurance card I have provided Provider. I assign exclusive and irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity in an amount of recovery not to exceed the extent of my bill for services provided by Provider, including exclusive and irrevocable right to receive payment for such services, make demand in my name for payments and prosecute and receive penalties, interest, court costs and other legally compensable amounts owed by an insurance company or other person or entity. I further authorize Provider to request and receive, on my behalf, from any insurance company or health care plan, any and all information and documents pertaining to my policy/plan, including a copy of the same and any information or supporting documentation concerning the handling, calculation, processing or payment of claims as such documents are required by law or regulation to be presented to me. In addition, I agree to cooperate and provide information as needed and appear as needed to assist in the prosecution of such claims for benefits upon request by Provider.

I hereby irrevocably designate, authorize and appoint Provider as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered by Provider. This power of attorney shall automatically terminate, without formal action being taken, as soon as Provider has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to me. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

I hereby instruct and direct my insurance company to pay Provider directly for medical services and care provided by Provider, and to provide to Provider any and all relevant information and documentation in connection with such payments and claims for payment. I understand that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I instruct that the insurer make out the check to me and mail payment directly to Provider at 17 Western Maryland Parkway, suite 100, Hagerstown, MD 21740, for the professional or medical expense benefits otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered by Provider. Upon receipt of said check, I authorize Provider to endorse such checks for deposit only, and to deposit and apply all the proceeds toward payment on my account.

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

If I am a Medicare or Medigap Benefit Participant I hereby authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or Carriers and/or Medigap insurance carrier, any information needed for this or related Medicare claim. I request PNSI bill claims directly to Medicare and/or Medigap and for payments to be received directly by PNSI. Medigap patients may receive the following message on their Explanation of Benefits: "Because you are assigned MEDIGAP benefits, information regarding your claim will be sent to your private insurer within 30 days." Section 4801 of the Omnibus Budget Reconciliation Act of 1987 provides an additional participation incentive for participating physicians by providing payment directly for assigned Medigap benefits.

I agree and understand that PNSI will charge and bill me directly for Administrative fees for Miscellaneous Services, including but not limited to, preauthorization for prescriptions and/ or imaging, insurance "Peer to Peer", psychological testing, Chlorhexidine preparation, medical record preparation, disability, motor vehicle and family medical leave forms, telephone consultation services for prescriptions and evaluation and management services.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize Provider to be my personal representative, which allows Provider to: (1) submit any and all appeals if and when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of Provider's billed charges, due upon receipt of invoice or statement from Provider, of any and all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, I agree to pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any fines levied against my insurance company will be paid to Provider for acting as my personal representative.

A photocopy of this Assignment shall be considered as effective and valid as the original.

____ ____________________________
Signature of Patient/Guarantor Date

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Witness