Neurosurgical Associates, Ltd

Patient Registration Form

PATIENT INFORMATION

Last Name | First Name | M

Birth Date __/__/____ Sex ☐M ☐F Social Security # _____

Address | Apt/Unit # | City | State | Zip

TELEPHONE CONTACT INFORMATION

Preferred Number

☐ Home Phone ___-___-____ Can we leave confidential messages regarding your care at this number? ☐ Yes ☐ No

☐ Mobile Phone ___-___-____ ☐ Yes ☐ No

☐ Work Phone ___-___-____ ☐ Yes ☐ No

AGE / MARITAL STATUS / EMAIL ADDRESS

Patient's Age

☐ Married
☐ Single
☐ Divorced
☐ Widowed
☐ Partner

Email Address

CURRENT WORK STATUS

☐ Full Time ☐ Unemployed ☐ Retired
☐ Part Time ☐ Disabled ☐ Self Employed

Employer

Job Title

PRIMARY CARE PHYSICIAN

Primary Care Physician Name | Clinic

REFERRING PHYSICIAN

Referring Physician Name | Clinic

PHARMACY INFORMATION

Pharmacy Name | Pharmacy Phone

Pharmacy Address

City | State | Zip

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Declined
☐ Native Hawaiian or Other Pacific Islander ☐ Other Race/ Not Reported ☐ White

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Not Reported

Preferred Language

☐ English ☐ Chinese ☐ German ☐ Arabic ☐ Somali ☐ Japanese ☐ Korean
☐ Spanish ☐ Russian ☐ Vietnamese ☐ Other

What country were you born in?

Please continue on other side

IN CASE OF EMERGENCY

Last Name | First Name

Address

City | State | Zip

Emergency Contact's Phone # ___-___-____

Relationship: ☐ Spouse ☐ Daughter ☐ Son ☐ Mother ☐ Father ☐ Sister ☐ Other

PARENT / GUARANTOR INFORMATION

Last Name | First Name | M

Birth Date __/__/____ | Age | Sex ☐M ☐F | Social Security #

Address | Apt/Unit #: | City | State | Zip

Home Phone ___-___-____ | Mobile ___-___-____ | Preferred ☐ Home ☐ Mobile

Relation to Patient ☐ Parent ☐ Guardian ☐ Spouse ☐ Employer

INSURANCE INFORMATION

Related to an accident? ☐ **No** ☐ **Yes** **Date of injury?** __/__/____ ☐ **Workers Comp** ☐ **Auto** ☐ **Other**

PRIMARY INSURANCE

Please give your insurance card to the receptionist

Insurance Carrier

Subscriber ID | Grp

Address

City | State | Zip

SUBSCRIBER INFORMATION

Name | Sex ☐M ☐F

Birth Date __/__/____ | Relation

Address

City | State | Zip

SECONDARY INSURANCE

Insurance Carrier

Subscriber ID | Grp

Address

City | State | Zip

SUBSCRIBER INFORMATION

Name | Sex ☐M ☐F

Birth Date __/__/____ | Relation

Address

City | State | Zip

HIPAA DISCLOSURE INFORMATION (Please check all that apply. At least one option must be checked)

The Patient/Guardian authorizes Neurosurgical Associates to contact them at:

☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Email Address (patient portal account required)

The Patient/Guardian authorizes Neurosurgical Associates to:

☐ Leave a detailed voicemail message ☐ Leave a call back number only

Often times following surgery or appointments, it may be necessary for spouses, family members or others to receive/obtain medical health information or advice on your behalf. Please list two individuals who are authorized to receive/obtain information from Neurosurgical Associates (NSA). NSA reserves the right to contact or speak to others not listed on this list if we feel the situation is an emergency.

Neurosurgical Associates is authorized to disclose information about the patient to the following people:

Parents/Guardians of minors do not need to list their name(s) below

Spouse's Name:

Other/Name Relationship:

Other/Name: Relationship:

This Authorization will be in effect until patient revokes in writing.

Patient Authorization and Consent Form

Assignment of Benefits and Release of Information. I request payment of authorized benefits directly to the provider for services furnished to me at this facility or any other facility owned or operated by Neurosurgical Associates, Ltd including physician services, or by any provider under contract with Neurosurgical Associates, Ltd or participating in a provider network in which Neurosurgical Associates, Ltd or its affiliates participate. I consent to the release of my health records and other information related to my health care services for payment and healthcare operations purposes. I agree that my health records and other information may be released to Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, in which my providers participate, and the contractors and third party administrators of any of these parties.

Release of Information by Payers and Networks: I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations including accountable care organizations, and their contractors and third party administrators to share my health records and information obtained from Neurosurgical Associates, Ltd or any other provider, with Neurosurgical Associates, Ltd, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which my provider participates, and the contractors and third party administrators of these parties as needed for payment and health care operations.

Release of Information to Health Care Providers. I consent to the release of my health records created, received and maintained by Neurosurgical Associates, Ltd for my treatment to other health care providers who are involved in my treatment. This consent does NOT include release of information obtained by or created in a drug or alcohol abuse treatment unit.

If Allina Laboratory Services are used: I understand that Neurosurgical Associates may release my health information to Allina Health System to provide certain lab services necessary for my treatment. I authorize Allina Health System to maintain health information about me in connection with such lab services in its system-wide electronic medical record system, and to permit other health care providers at non-Allina facilities to access such laboratory records for my treatment.

This consent will continue until revoked unless you cancel it in writing by writing us at:

Neurosurgical Associates, Ltd
800 E 28th Street, Suite 305 Piper Building
Minneapolis, MN 55407

If the consent is cancelled, it will not change releases that have already been made.

I have received and reviewed the patient authorization and consent policy

_____ _____

Signature of Patient or Patient Representative ***Date***

_____ _____

Relationship to patient (if unable to sign) ***Reason Patient Unable to Sign***