



SOUTHWEST FLORIDA NEUROSURGICAL ASSOCIATES

SOUTHWEST FLORIDA REHAB & PAIN MANAGEMENT ASSOCIATES

PLEASE PRINT CLEARLY, BOTH SIDES OF FORM

DATE _____

NAME _____ HOME PHONE _____

LAST

FIRST

MI

SEX: M F AGE: ____ BIRTHDATE: ____/____/____ SOCIAL SECURITY #: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____ SPOUSE'S EMPLOYER: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ IS ADDRESS: PERMANENT ____ TEMPORARY ____

OTHER ADDRESS IF ABOVE IS TEMPORARY: _____

PATIENT'S EMPLOYER: _____ WORK PHONE: _____ YEARS EMPLOYED: _____

DRIVER'S LICENSE #: _____ STATE: _____

INSURANCE INFORMATION (Please present your insurance card(s) for copying)

MEDICARE #: _____ **MEDICARE SUPPLEMENT:** _____

HEALTH INSURANCE: _____ **POLICY #:** _____ **GROUP #:** _____

POLICY HOLDER'S NAME: _____ **RELATIONSHIP TO PATIENT:** _____

BIRTHDATE: ____/____/____ **SOCIAL SECURITY #:** _____

IF VISIT IS RELATED TO WORK COMP OR AN ACCIDENT, PLEASE COMPLETE BELOW

WORK COMP: **EMPLOYER NAME:** _____ **PHONE:** _____

ADDRESS: _____ **DATE OF ACCIDENT:** _____

ACCIDENT: **AUTO ACCIDENT:** _____ **OTHER (STATE TYPE):** _____

INSURANCE CARRIER: _____ **POLICY #:** _____

CLAIM #: _____ **DATE OF ACCIDENT:** _____ **POLICY HOLDER'S NAME:** _____

BIRTHDATE: ____/____/____ **SOCIAL SECURITY #:** _____ **RELATIONSHIP TO PATIENT:** _____

ARE YOU REPRESENTED BY AN ATTORNEY? ____ **ATTORNEY'S NAME:** _____ **PHONE #:** _____

IF PATIENT IS A MINOR, PLEASE COMPLETE BELOW

MOTHER'S NAME: _____ **EMPLOYER:** _____

HOME ADDRESS: _____ **PHONE #:** _____

MOTHER'S SOCIAL SECURITY #: _____ **WORK PHONE #:** _____

FATHER'S NAME: _____ **EMPLOYER:** _____

HOME ADDRESS: _____ **PHONE #:** _____

FATHER'S SOCIAL SECURITY #: _____ **WORK PHONE #:** _____

PLEASE COMPLETE

REFERRING DOCTOR: _____ **PHONE #:** _____

REASON FOR VISIT: _____

EMERGENCY CONTACT (not living with you): NAME: _____

EMERGENCY PHONE #: _____

LETTER OF PROTECTION AUTHORIZATION

I authorize my attorney, _____, to provide to Sypert Institute, P.A. a letter of protection. I understand that this will authorize my attorney to protect the medical provider's unpaid bill and pay the same from any settlement I might receive. This does not relieve me from the responsibility to provide my medical provider(s) with insurance information so the insurance can be filed. NOTE: All managed care copays must be paid at time of service.

PATIENT'S SIGNATURE

MEDICARE/CHAMPUS AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical provider(s) services to the medical provider(s) furnishing the services and authorize such medical provider(s) to submit a claim to Medicare for payment.

SIGNED _____ DATE _____
PATIENT'S SIGNATURE (OR PARENT IF MINOR)

AUTHORIZATION TO RELEASE INFORMATION

I authorize any holder of medical or other information about me to release same to the insurance carrier for the purpose of payment of services.

I hereby authorize payment directly to my medical provider for all medical care benefits otherwise payable to me; this is not to be construed as an assignment of benefits unless the medical provider has a contractual agreement with the insurance company. I understand that I am responsible for any insurance deductibles and coinsurance, and I am financially responsible for my medical bills regardless of insurance coverage.

SIGNED _____ DATE _____
PATIENT'S SIGNATURE (OR PARENT IF MINOR)

PATIENT — PLEASE NOTE:

This office will prepare and file your insurance for you. If you choose to file your own, please check all data before forwarding to your insurance company. Our office will expect payment in full on the date services are rendered if you are filing your own claim. There will be a \$20.00 charge for each special form you request us to complete, such as disability forms, family medical leave, etc.

I understand that if my insurance carrier controverts or rejects my claim that I/we (am/are) responsible for all charges billed by this office.

Managed Care Patients: There will be a \$10.00 processing fee billed to your account each time you do not pay your required co-payment at time of service.

For, and in consideration of, services rendered to the above named patient, I/we jointly and severally promise to pay to the Sypert Institute, P.A. (dba as Southwest Florida Neurosurgical Associates and/or Southwest Florida Rehab & Pain Management Associates) all its charges for services rendered to and for the above named patient. I/we understand the Sypert Institute, P.A. may elect to accept or not to accept assignment of insurance benefits as it deems advisable. Any other arrangements made by me (insurance company, lawyers, etc.) does not involve the Sypert Institute, P.A. and does not change my (our) responsibility to pay for services.

All patients (excluding contracted third party payors) are assessed a 1% monthly billing fee on any balance over 120 days. I have read and understand all of the above.

(PATIENT)

(GUARANTOR)