East Alabama Neurosurgery and Spine
1957 E Samford Ave Ste A
Auburn, AL 36830
Phone: 334-209-5400
Fax: 334-209-4110

Please email completed form and a copy of your insurance and ID cards to **contact@eaneurospine.com**

New Patient Registration

PATIENT INFORMATION

Name (First, Middle, Last): _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Gender: _____

Race: _____ Occupation: _____

Cell Phone: (_____)_____ Home Phone: (_____)_____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone: (_____)_____ Relationship: _____

INSURANCE

Primary Insurance

Plan Name: _____ Member ID #: _____

Insured's Name: _____ Insured's DOB: _____ Group #: _____

Insured's Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other: _____

Secondary Insurance

Plan Name: _____ Member ID #: _____

Insured's Name: _____ Insured's DOB: _____ Group #: _____

Insured's Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other: _____

MEDICAL HISTORY

Were you referred to our office? ❑ Yes ❑ No If yes, by whom? _____

Reason for Visit: _____

EAST ALABAMA NEUROSURGERY AND SPINE

Please email completed form and a copy of your insurance and ID cards to **contact@eaneurospine.com**

MEDICAL HISTORY

Please List Any Current or Past Medical Problems (including surgical) and Approximate Dates:

_____

_____

_____

Please List All Current Medications, Dosage, and Duration: _____

_____

_____

Please List Any Known Medication Allergies: _____

_____

Social History – please check if you use any of the following:

Tobacco (cigarette or vape) ❑ Yes ❑ No If yes, how often/ long? _____

Alcohol ❑ Yes ❑ No If yes, how often/ long? _____

Illicit Drugs ❑ Yes ❑ No If yes, how often/ long? _____

Medical History – please check if any of the following apply:

❑ Hypertension ❑ Diabetes ❑ CAD ❑ Stroke ❑ Heart Disease ❑ Cancer ❑ HIV

❑ DVT/ Blood Clot ❑ Seizures ❑ Headaches/ Migraines ❑ Osteoporosis ❑ COPD

❑ Lower Back Pain ❑ Pacemaker/ AICD ❑ Bowel/ Bladder Abnormalities ❑ Kidney Disease

❑ Pregnancy (past or present) ❑ Miscarriage

Family History – please check if any of the following apply:

❑ Cancer ❑ Diabetes ❑ Heart Disease ❑ Stroke/ DVT/ Blood Clotting Disorder ❑ High Blood Pressure

Have you ever had any of the following?

❑ MRI ❑ XRAY ❑ CT ❑ MYELOGRAM ❑ EMG

The above information is true to the best of my knowledge.

Patient Signature: _____ **Date:** _____

EAST ALABAMA NEUROSURGERY AND SPINE

Please email completed form and a copy of your insurance and ID cards to **contact@eaneurospine.com**

FINANCIAL POLICY – PLEASE INITIAL AND SIGN BELOW

_____ I authorize East Alabama Neurosurgery and Spine to collect insurance benefits on my behalf, and to release my medical chart to my insurance company. I understand that any amount quoted to me for a service is an estimate, not a guarantee, and any remaining balance is my responsibility. **I understand as a patient, I am responsible for any co-payments, coinsurance, and deductibles that are not covered by insurance. These amounts are due prior to services rendered.**

_____ I authorize my insurance benefits to be paid directly to East Alabama Neurosurgery and Spine. I understand that I am financially responsible for any balance not covered by my insurance. I authorize East Alabama Neurosurgery and Spine to release any information required to process my claims. I understand that EANS accepts many major medical plans. However, it is my responsibility to confirm that EANS is in-network with my insurance provider before services are rendered.

_____ I understand East Alabama Neurosurgery and Spine may recommend medical treatment including labs, imaging, surgery, office visits at EANS or another practice, etc. that may not be covered by my insurance plan. I understand EANS recommends this treatment based on medical necessity and not insurance coverage prior to services rendering. I understand it is my responsibility to verify coverage and benefits with my insurance company. I understand that any unpaid balance is my financial responsibility.

_____ I authorize East Alabama Neurosurgery and Spine permission to give and obtain my medical, pharmacy, personal, and billing information from other facilities, agencies, companies, physicians, etc. via electronic, email, fax, mail, and phone.

_____ I understand any requests to EANS regarding completion of any paperwork including forms, letters, etc., such as disability or FMLA, describing my medical condition or treatment is subject to a $30 fee per request. I understand this fee is nonrefundable and not covered by insurance.

Missed Appointments and Late Cancellations: We require 24-hour notice for cancellations or rescheduling of appointments. If you miss an appointment or cancel with less than 24 hours' notice, you may be charged a missed appointment fee. The no show fee for office appointments is $50. The no show fee for surgery is $250. Fee must be paid prior to rescheduling your appointment.

Collections: If an account becomes past due, our office may send reminder notices. After 90 days of non-payment, we reserve the right to send the balance to a collection agency. The patient will be responsible for any collection fees, legal fees, or other charges incurred in the process. Patients who have been sent to collections may be discharged from the practice.

Responsibility for Charges: The person who seeks medical services is responsible for all fees and charges. If the services are provided to a minor or dependent, the responsible party (e.g., parent or guardian) will be held liable for payment.

Acknowledgment: By signing below, you acknowledge that you understand and agree to the financial policy outlined above. You agree to be financially responsible for any charges not covered by insurance and to adhere to the office's payment practices.

HIPAA Privacy Acknowledgment and Waiver: By signing below, you acknowledge that you have received or been given the opportunity to review the healthcare provider's Notice of Privacy Practices, which outlines how my medical information will be used and disclosed. You understand that your protected health information (PHI) will be maintained in accordance with the Health Insurance Portability and Accountability Act (HIPAA). You consent to the use and disclosure of my medical information for treatment, payment, and healthcare operations as described in the Notice of Privacy Practices. You understand that you have the right to revoke this authorization in writing at any time, except where action has already been taken in reliance on this consent. You also consent to the release of your medical information to individuals or entities involved in your care or payment for care as necessary.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

EAST ALABAMA NEUROSURGERY AND SPINE

Please email completed form and a copy of your insurance and ID cards to **contact@eaneurospine.com**

DISCLOSURE OF HEALTH INFORMATION

By signing this form, I hereby authorize use and/or disclose of my protected health information about me to the following individual(s):

Name: _____

Phone Number: _____ Relationship: _____

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. Information used or disclosed may be used by the person I have authorized above for the purposes of medical treatment or continuation, billing or claim payments, or other purposes. By making this authorization, I understand that the information provided may no longer be protected by federal or state laws.
2. I have the right to revoke this authorization at any time by writing to East Alabama Neurosurgery and Spine. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
3. I understand signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

This authorization shall in force and in effect until _____, at which time the authorization expires.

Patient Name (please print): _____

Patient Signature: _____ Date: _____