

Neurosurgery & Spine Surgery, S. C.

MICHAEL H. RABIN, MD, FACS
JOHN BRAYTON, MD, FACS

1551 BOND STREET, # 143
NAPERVILLE, IL 605 63

1797 W. STATE STREET, # C
GENEVA, IL 60134

PHONE: (630) 983-7100

COMMUNICATION METHODS YOU MAY USE TO CONTACT ME:

Leave message on home answering machine: _____ Yes _____ No

You may call me at work: _____ Yes _____ No

Leave message on a work voice mail: _____ Yes _____ No

Contact me by Fax: _____ Yes [Fax # (____) _____] _____ No

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I, _____, hereby authorize the staff of
(Name of Patient or Authorized Agent)
Neurosurgery & Spine Surgery to communicate with the following person(s) regarding my
medical condition, testing results, films, medication, medical needs, insurance and patient
account balances:

Full Name:

Relationship:

Phone #:

_____	_____	(H) _____
		(C) _____
		(W) _____
_____	_____	(H) _____
		(C) _____
		(W) _____

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____

ACCT # _____

PATIENT INFORMATION

PRIMARY INSURANCE IF APPLICABLE

(PPO/POSEPO)

PATIENT NAME _____ Male / Female

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

HM PH (____) _____ CELL PH (____) _____ WK PH (____) _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

SPOUSE/GUARDIAN _____

REFERRING DR: _____ PHONE (____) _____

STREET _____

CITY _____ STATE _____ ZIP _____

GUARDIAN IF NOT LIVING WITH YOU (if applicable)

NAME _____ PHONE (____) _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

ANOTHER CONTACT PERSON - IF EMERGENCY:

NAME _____ RELATIONSHIP _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

HM PH (____) _____ CELL PH (____) _____ WK PH (____) _____

CREDIT CARD REFERENCES: VISA MASTERCARD DISCOVER AMER EXPRESS

CARD # _____ EXPIRES _____

TERMS AND CONDITIONS _____

INS. CO. NAME: _____ (PPO/POSEPO)

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PH # (____) _____ ID# _____ GROUP # _____

EMPLOYER _____ SUBSCRIBER NAME _____

DATE OF BIRTH _____ SS # _____

INS. CO. NAME: _____ SECONDARY INS. IF APPLICABLE

STREET ADDRESS _____ (PPO/POSEPO)

CITY _____ STATE _____ ZIP _____

PHONE # (____) _____ SUBSCRIBER NAME _____

DATE OF BIRTH _____ ID # _____ GROUP # _____

• IF YOU HAVE A 3rd INS. ID CARD IT WILL BE COPIED (CHECK HERE) _____

AUTO ACCIDENT: (IF APPLICABLE)

ACCIDENT DATE _____ CLAIM # _____

RESPONSIBLE PARTY INSURED'S NAME _____ RELATIONSHIP _____

INSURANCE COMPANY _____

INSURANCE CO. ADDRESS _____

CITY _____ STATE _____ ZIP _____

(IF APPLICABLE) ATTORNEY: NAME _____ PHONE (____) _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

I acknowledge that I am financially responsible for all services rendered to me. Although I have requested my physician to bill my insurance company, workman's compensation, or third parties who may be responsible to me for this bill, I remain personally and primarily responsible to the doctor for payment for all services billed. ■ Should the account go into collection status, I will be responsible for all collections costs, including attorney fees and court costs. ■ In the event that any amount remains unpaid by me more than 120 days after billing, you may submit this bill to the credit card account listed on this form for payment. There will be a 1.5% per month finance charge added to my account after 120 days. ■ I request that Neurosurgery & Spine Surgery, S.C., release any information required to process this claim and maintain the status of that claim, and I authorize my insurance benefits to be paid directly to Neurosurgery & Spine Surgery, S.C.

Signature _____ DATE _____ (OVER)