

1 Lincoln Parkway, Suite 300  
Hattiesburg, MS 39402

**PATIENT REGISTRATION**

**PATIENT INFORMATION**

Referring Physician \_\_\_\_\_ Primary Physician \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M  F  Social Security Number \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Alternate Phone ( ) \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Phone ( ) \_\_\_\_\_

Employer Address \_\_\_\_\_ City, ST, ZIP \_\_\_\_\_

If patient is a student please indicate school attending: \_\_\_\_\_ Email Address: \_\_\_\_\_

Marital Status:  Single  Married  Widow  Divorced  Separated

**PATIENT'S SPOUSE**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M  F  Social Security Number \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Phone ( ) \_\_\_\_\_

Employer Address \_\_\_\_\_ City, ST, ZIP \_\_\_\_\_

**EMERGENCY INFORMATION** *(Please list the name of someone who does not live with you to contact in the event of an emergency)*

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_

**VISIT INFORMATION**

Is this visit today work related? Yes  No  If yes, date of injury \_\_\_\_\_

Is this visit today related to an auto accident? Yes  No

Is there a 3<sup>rd</sup> party involved? Yes  No  If so, Name \_\_\_\_\_ Insurance \_\_\_\_\_

**FINANCIAL POLICY**

I am responsible for payment of services rendered to me by this clinic. (If the patient is under 18, the parent or legal guardian assumes responsibility of all charges.) Full payment is due at the time of service. I understand that if my account should ever require action by a collection agency or attorney in order to insure payment, the fees charged by these agents may be added to the balance due on the account. My signature below acknowledges understanding and agreement to the above reference policy.

\_\_\_\_\_  
Patient Signature (Parent or Legal Guardian if minor)

\_\_\_\_\_  
Date

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**INSURANCE INFORMATION****Primary Insurance Name** \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Effective Date \_\_\_\_\_

Name of Insured \_\_\_\_\_ Insured's Phone Number ( ) \_\_\_\_\_

Insured's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured's Sex M  F 

Address of Insured \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

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**Secondary Insurance Name** \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Effective Date \_\_\_\_\_

Name of Insured \_\_\_\_\_ Insured's Phone Number ( ) \_\_\_\_\_

Insured's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured's Sex M  F 

Address of Insured \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

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Guarantor's Name \_\_\_\_\_ Guarantor's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Guarantor's Billing Address \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Guarantor's Phone Number ( ) \_\_\_\_\_

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**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

Southern Neurologic & Spinal Institute's Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review the Notice before signing this consent. As provided in the notice, the terms or our Notice may change. If we change our Notice, you may obtain a revised copy by requesting a copy from our Administrative Office by writing 1 Lincoln Parkway, Suite 300 Hattiesburg, MS 39402.

You have the right to request that Southern Neurological & Spinal Institute restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to such a restriction, but if we do, are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about your treatment and health care operations (including HIV testing and drug and alcohol screening, if applicable). You have the right to refuse signing this consent and the right to revoke this consent in writing, except when we have already made disclosures in reliance to your prior consent. This consent will expire two years from the date below.

Name: \_\_\_\_\_  
Name of Patient Patient Signature (Parent or legal guardian) Date

I am responsible for payment of services rendered to me by this clinic. (If the patient is under 18, the parent or legal guardian assumes responsibility of all charges.) Full payment is due at the time of service. I understand that if my account should ever require action by a collection agency or attorney in order to insure payment, the fees charged by these agents may be added to the balance due on the account. I authorize Southern Neurologic & Spinal Institute and all employees and other personal of/or associated with Southern Neurologic & Spinal Institute to have access to my existing and future medical records and copies thereof in connection with all medical services or treatment under confidentiality which I may now or hereafter receive from the staff.

I hereby also authorize payment of medical benefits to Southern Neurologic & Spinal Institute for all services provided to me. I authorize the physician to release any information acquired in the course of my treatment to process insurance claims, workers compensation claims, or any other agent that has been involved in my medical treatment. I also permit release of medical information to continue the process of care on my behalf. All other releases will require a release of information form to be completed.

I hereby acknowledge and agree to accept the policies as stated above.

\_\_\_\_\_  
Signature of Patient (Parent or Legal Guardian) Date