

# Carolina Spine Center

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First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_\_ SS: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

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In the event of an emergency please contact: \_\_\_\_\_

Relation to contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

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Referring Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone#: \_\_\_\_\_

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Payment Method: Insurance [  ] Self Pay [  ] Workers Compensation [  ]

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_

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## HIPPA Notice of Privacy Practices Acknowledgement & Authorization of Release

HIPPA Notice of Privacy Practices is attached to this clip board and can be provided to the Patient upon their request.

Please review and feel free to ask any questions regarding the Privacy Practice Notice.

I authorize the release of medical information for the coordination and management of my healthcare.

I authorize the release of medical information to obtain payment for healthcare services.

I authorize the release of medical information to:

Spouse: \_\_\_\_\_

Child(ren): \_\_\_\_\_

Other: \_\_\_\_\_

Signature: \_\_\_\_\_

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