CAROLINA NEUROSURGERY & SPINE ASSOCIATES

Carolina Neurosurgery & Spine Associates
225 Baldwin Avenue
Charlotte, NC 28204-3109
(704) 376-1605

PATIENT INFORMATION

NAME (Last, First Middle)	MRN		BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP / HOME PHONE	CITY, STATE ZIP / HOME PHONE

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME	CONTACT HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)		BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT $	
CITY, STATE ZIP	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT $	
CITY, STATE ZIP	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

FINANCIAL POLICY/AUTHORIZATION TO RELEASE INFORMATION TO PAY

I understand that I am responsible for all medical expenses, regardless of insurance coverage and whether or not there is an accident with another person at fault. I hereby authorize CNSA to release any information acquired in my treatment to the insurance company (ies) listed above. I hereby authorize payment directly to CNSA for treatment. In order to obtain proper authorizations, by signing below I verify that I have presented correct insurance card(s).

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____