



**Patient Information/Assignment of Benefits/Release of Info/HIPAA/Rights and Responsibility Acknowledgement**

Name _____	Sex	M	F	Birthdate _____
Address _____		Phone # _____		
E-mail _____		Emergency Contact/Phone # _____		

**Assignment and Release**

- I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to **Microsurgical Spine Center** all insurance benefits, if any, otherwise payable to me for services rendered.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I authorize the use of my signature on all insurance submissions.
- The above named healthcare provider/institution may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.
- This consent will end my current treatment plan if completed one year from the date signed below.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please Print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

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

**Release of Healthcare Information:**

**Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition or death.**

**To whom may we disclose your protected healthcare information to:**

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**By signing below, I hereby acknowledge that I have reviewed and/or received a copy of Microsurgical Spine Center Notice of Privacy Practices and Patient Rights and Responsibilities, as of the date set forth below.**

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date