Center for Cranial and Spinal Surgery

1830 Town Center Drive, #103
Reston, Virginia 20190
(703) 560-1146

PATIENT REGISTRATION • *Please Print Clearly*

PATIENT NAME First	Middle	Last			DATE OF BIRTH	AGE
HOME ADDRESS	Apt. No.	CITY		STATE	ZIP CODE	
EMAIL ADDRESS					CELL PHONE	
OCCUPATION	SOCIAL SECURITY NO.		MARITAL STATUS	SEX	HOME PHONE	
EMPLOYER	ADDRESS				WORK PHONE	
SPOUSE'S NAME (OR PARENT)	SPOUSE'S EMPLOYER (OR PARENT)				SPOUSE'S WORK PHONE (OR PARENT)	
SPOUSE'S OR PARENT'S ADDRESS						
NEAREST RELATIVE/FRIEND	RELATIONSHIP	HOME PHONE			WORK PHONE	
RELATIVE/FRIEND'S ADDRESS						
REFERRING PHYSICIAN	ADDRESS				TELEPHONE	

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Charges for office visits and surgery are reasonable and vary with the problem to be treated. We will discuss these at your request. Payment of your co-pay at the time of your visit is expected. Our office policy regarding insurance is that we will file your primary claim. We do not accept assignment of insurance as payment in full. The balance of fees not covered by insurance is the responsibility of the patient. In the event your account is placed in the hands of any attorney for collection, you agree to pay all costs and expenses, including a 25% attorney fee related to the collection thereof. If you wish to arrange a payment plan we will assist you. However, our office does not extend credit.

BILLING AND INSURANCE INFORMATION

SEND BILL TO	FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT
	HOME ADDRESS	CITY	STATE ZIP CODE
	EMPLOYER	WORK PHONE	HOME PHONE
PRIMARY INSURANCE	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP / CODE
	INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE
	SUBSCRIBER'S NAME	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS	WORK PHONE	SUBSCRIBER'S DATE OF BIRTH
SECONDARY INSURANCE	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP / CODE
	INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE
	SUBSCRIBER'S NAME	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS	WORK PHONE	SUBSCRIBER'S DATE OF BIRTH

PATIENT'S AUTHORIZATION

I hereby authorize the Center for Cranial and Spinal Surgery to apply for benefits on my behalf for covered services rendered by Center for Cranial and Spinal Surgery and that payment be made directly to Center for Cranial and Spinal Surgery for said services.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to determine benefits to which I may be entitled.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked either by me or my insurance carrier at any time in writing.

I will be responsible for the balance of charges not covered by my health insurance.

Signature of Subscriber or Beneficiary _____ Date _____

PATIENT ACCOUNT NO: _____

FOR ACCIDENTS OR INJURIES, PLEASE COMPLETE THE INFORMATION ON REVERSE

ACCIDENT OR WORKERS' COMPENSATION INFORMATION

Description of Accident			
Description of Injury			Date of Injury
Description of Current Problem			Date of Onset
Were You Treated by a Physician?	☐ Yes	☐ No	
By Whom?			
Where?			
X-Rays / CAT Scan / MRI Taken?	☐ Yes	☐ No	
Where?			

IF DUE TO WORKERS' COMPENSATION OR ACCIDENT, FILL OUT INFORMATION BELOW

Compensation Carrier	Claim No. (if known)
Address of Compensation Carrier	Phone
Employer At Time of Accident and Address	