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Patient Name

HIGHLANDS NEUROSURGERY

Consent for Treatment

1. General Consent for Treatment and Tests: I consent to treatment by the Highlands Neurosurgery physicians and staff for my illness and/or health evaluations, including but not limited to x-rays, blood tests, laboratory procedures, medications, and minor procedures. I acknowledge and agree that NO GUARANTEES have been made to me as to the results or outcome of my medical care. I understand that State Law requires physicians to report certain communicable diseases to the Health Department.

2. Release from Liability for Leaving Against Medical Advice: I agree that if I leave a physician's office against the advice of my physician or the Highlands Neurosurgery staff, then Highlands Neurosurgery, its personnel, and my physician(s) are released from responsibility or liability for any injuries or damages which may result from my leaving against medical advice.

3. Authorization to Release Medical Information: I authorize Highlands Neurosurgery and all physicians involved in my care to disclose and release my medical information (which may include alcohol and drug abuse, psychiatric, sickle cell anemia, AIDS and HIV test results) to each other and to any person or organization which is or may be liable or responsible for payment of my bill, including Medicare intermediaries and fiscal agents.

4. Assignment of Insurance Benefits / Promise to Pay: For and in consideration of services rendered and to be rendered by Highlands Neurosurgery, I hereby guarantee payment for all charges incurred for the account of the above named patient. I understand and agree that payment for such services shall be due at the time of service. I authorize and direct any person, firm, or corporation, including but not limited to, insurance companies or attorneys representing the patient or any other party, for such services to assign proceeds of any payment for services rendered to said patient directly to Highlands Neurosurgery. I understand that by Highlands Neurosurgery accepting assignment of said benefits, the provider does not relinquish its right to collect any balance not paid by any third party. I further agree that if such indebtedness is placed in hand of collector or attorney, for collections, I will pay reasonable collection fees and attorney fee, interest, court costs and other collection expenses.

I have read and understand this document, and I agree to its terms.

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**Patient / Authorized Party**

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**Relationship**

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**Date**

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**Witness**

# HIGHLANDS NEUROSURGERY

## PATIENT INFORMATION

Patient's Name	Social Security Number	Marital Status	Sex	Birth Date	Age
Street Address			City /State/Zip		Home Phone
Patient's Employer	Occupation or Student	How Long?		Work Phone	
Employer's Address			City/State/Zip		
Spouse or Parent Name		Social Security Number		Birth Date	
Spouse's Employer and Address			City/State/Zip		
Referring Physician or Company		Address		Phone Number	
Family Doctor		Address		Phone Number	
Has any member of your immediate family been treated by our physicians?    Y / N If so, please name:					
Emergency Contact Name			Emergency Contact Phone Number Home                      Work                      Other		
Primary Insurance Company		Insured		Relationship to Patient	
Policy Number		Group Number		Insured Employer	
Secondary Insurance Company		Insured		Relationship to Patient	
Policy Number		Group Number		Insured Employer	
Is your illness/injury due to an auto accident due to an auto accident    Y / N Is your illness/injury due to a work related injury    Y / N *** If you answered YES to either of the above questions, please fill out the appropriate information below:					
<b>Auto</b>			<b>Work Comp</b>		
Date of Accident		Location of Accident		Date of Injury	
				Last Date Worked	
How were you injured ?			How were you injured ?		
Auto Insurance		Insured's Name		Work Comp Carrier and Address	
Policy Number		Claim Number		Claim Number	
Fault of another party?    Y / N			Do you have an attorney?    [ ] Yes    [ ] No		
Name and insurance company of liability insurer			Name		Address                      Phone
Claim Number		Policy Number			
Do you have an attorney?    [ ] Yes    [ ] No					
Name		Address		Phone	