Minimally Invasive Spine Institute
OUTPATIENT SPINE SURGERY CENTER

Patient Information/Advance Directive/Assignmentof Benefits/Release of Info/HIPAA/Rights and Responsibility/Disclosure of Ownership Acknowledgement

Name _____ **Sex M F Birthdate** _____

Address _____

Phone # _____ **Emergency Contact/Phone #** _____

E-mail _____

(Email will only be utilized for patient satisfaction surveys through NRCPicker, a HIPAA compliant company)

Do you have an Advance Directive: ☐Yes ☐No Did you provide a copy to the facility: ☐Yes ☐No ☐NA

Would you like to be provided information on Advance Directives: ☐Yes ☐No

Assignment and Release

I certify that I, and /or my dependent(s), have insurance coverage with _____ and assign directly to **Minimally Invasive Spine Institute** 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 was given a copy of Minimally Invasive Spine Institute Notice of Privacy Practices, Patient Rights and Responsibilities and Physician Disclosure of Ownership and Advance Directive information if requested.

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Witness Date