SONSA
SOUTHERN OREGON NEUROSURGICAL & SPINE ASSOCIATES, PC.
2900 State Street • Medford, Oregon 97504 541-779-1672 WWW.SONSA.ORG

PLEASE COMPLETE BOTH SIDES OF THIS FORM (PLEASE PRINT)

PATIENT INFORMATION

Last Name_____ First Name_____ Middle Initial_____

Mailing Address_____ City_____ State_____ Zip Code_____

Home Phone ( )_____ Cell Phone ( )_____

SSN_____ Date of Birth_____ Age_____ [ ] Male [ ] Female

Primary Care Physician_____ Referring Physician_____

Have you been seen by one of our physicians previously [ ] Yes [ ] No Previous Name_____

PATIENT'S EMPLOYMENT INFORMATION

[ ] Employed [ ] Retired [ ] Student [ ] Other Employer_____

Occupation_____ Work Phone ( )_____

EMERGENCY CONTACT

Name_____ Phone ( )_____ Alternate Phone ( )_____

Relationship to Patient_____

How did you hear about us? _____

May we leave a message on your answering machine? [ ] Yes [ ] No

May we call you at work? [ ] Yes [ ] No

May we discuss your care with a family member? [ ] Yes [ ] No If yes, Name_____

INSURANCE INFORMATION

Primary Insurance Company Name_____

Policy #_____ Group #_____

Policy Holder_____ SSN_____ Date of Birth_____ Sex [ ] M [ ] F

Relationship to Patient_____ Policy Holder's Employer_____

Secondary Insurance Company Name_____

Policy #_____ Group #_____

Policy Holder_____ SSN_____ Date of Birth_____ Sex [ ] M [ ] F

Relationship to Patient_____ Policy Holder's Employer_____

Is this visit related to any of the following: [ ] Worker's Compensation Injury [ ] Motor Vehicle Accident [ ] Personal Injury

If yes, Insurance Company Name_____ Claim #_____

Insurance Company Phone ( )_____ Date of Injury_____

If Worker's Compensation Injury, Employer at time of Injury_____

(Over)

NO-SHOW/CANCELLATION POLICY FOR DOCTOR APPOINTMENTS

At SONSA, our goal is to provide the highest quality neurosurgical care in a timely manner. Because our patient office visits are in great demand, we have implemented an appointment no-show/cancellation policy which enables us to better utilize available appointments for patients in need of neurosurgical care.

- If it is necessary to cancel your scheduled office appointment, we require that you give at least a 24 hour notice. Patients who fail to show for their scheduled appointment or do not notify the office within 24 hours of their scheduled appointment time shall be subject to a "No Show" fee of $25. This fee will not be billed to insurance and will be collected before another appointment is scheduled.
- In the event of an actual emergency and prior notice could not be given, consideration will be given on a case-by-case basis.

CHANGING PROVIDERS ONCE ESTABLISHED

Once established as a patient at SONSA, we do not allow patients to change Neurosurgeons within the practice. For second opinions, we can provide you with name(s) of surgeons outside of the practice.

FINANCIAL POLICY

You are responsible for your bill. Patients with Private Insurance, Medicare, or Medicaid are responsible for any visit co-payments, percentage and/or deductible amount not yet met at the time service is rendered. As a courtesy to you, we will submit an insurance claim to your primary and secondary insurance carrier. Any amount not covered by your insurance must be paid by you.

Patients without insurance must pay for the visit in full at the time service is rendered, unless prior payment arrangements have been made with our business office.

Failure to make prompt payments may result in your balance being turned over to an outside collection agency and/or denial of future credit or service.

There is a $25.00 charge for returned checks.

Should it become necessary to collect monies in court, all court costs and attorney fees are the responsibility of the patient.

MasterCard, Visa, Discover, American Express and Visa/MasterCard debit are accepted for your convenience.

AUTHORIZATION TO PAY; RELEASE MEDICAL INFORMATION

I have read and agree to the Financial Policy listed above. I hereby assign all payment directly to Southern Oregon Neurosurgical & Spine Associates, PC to which I am entitled for expenses related to services performed. I understand that I am financially responsible for all charges. Photocopies of this assignment are considered as originals.

I authorize Southern Oregon Neurosurgical & Spine Associates PC the release of any information as may be required by an attorney, insurance company, or referring physician for the purpose of medical treatment.

X_____ _____

Signature of Patient (Parent/Guardian if patient is a minor) Date

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the Southern Oregon Neurosurgical & Spine Associates, PC, Notice of Privacy Practices.

X_____ _____

Signature of Patient (Parent/Guardian if patient is a minor) Date