

# Yakima Neurosurgery Associates

(In Association with Memorial Physicians, LLC)

## Patient Registration

### Patient Information

**Please use your full name as it appears on your insurance or Medicare Card. No Nicknames.**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Physician \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex: M F Married Single Other Soc. Sec# \_\_\_\_\_

Employer \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Phone \_\_\_\_\_

### Guarantor (Responsible for Account)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work phone \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex: M F Married Single Other Soc. Sec.# \_\_\_\_\_

**Patient has no insurance, is private pay. Patient's Signature (Or Legal Guardian):** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Insurance Information (COPY CARD (s) FRONT & BACK)

Primary Insurance Company \_\_\_\_\_ Subscriber ID \_\_\_\_\_

Group ID \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Effective Date \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Sex: M F Birth Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Co Pay \$ \_\_\_\_\_ Referral Needed? Y N

Secondary Insurance Company \_\_\_\_\_ Subscriber ID \_\_\_\_\_

Group ID \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Effective Date \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Sex: M F Birth Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Co Pay \$ \_\_\_\_\_ Referral Needed? Y N

### AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I authorize my insurance benefits (including Medicare) to be paid directly to Medical Associates of Yakima, LLC for services rendered. I also authorize Medical Associates of Yakima, LLC on Behalf of \_\_\_\_\_ to release any information requested by the insurance company with regard to payment of benefits.

I \_\_\_\_\_ the parent/legal guardian of \_\_\_\_\_ authorize & consent to routine & emergency medical services to be performed for my child when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

I authorize Medical Associates of Yakima, L.L.C. or any collection agencies used by Medical Associates of Yakima, L.L.C. to contact me by my cellular telephone for billing activities or payment arrangements.

\_\_\_\_\_  
Patient's signature (Or Legal Guardian) Date

\_\_\_\_\_  
Patient's Signature (Or Legal Guardian) Date