ROCKY MOUNTAIN
NEUROSURGERY

PATIENT INFORMATION

Full Patient Name _____

Address _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

Date of Birth _____ Age _____ SSN _____

Employer _____ Pharmacy Name & Phone # _____

RESPONSIBLE PARTY (ONE WHO CARRIES THE INSURANCE) – IF YOU ARE THE POLICY HOLDER, PUT SELF

Policy Holder Name _____ Relationship to Patient _____

Date of Birth _____ SSN _____

Address _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Employer _____

INSURANCE INFORMATION (Please present insurance card(s) to front desk so copy can be made)

Primary Insurance _____ ID# _____ Group# _____ Copay $_____

Secondary Insurance _____ ID# _____ Group# _____ Copay $_____

Are we billing a Worker's Compensation Insurance? ☐Yes ☐No

Claim #_____ Adjuster Name _____ Adjuster Phone #_____ Adjuster Fax# _____

Are we billing a Medicare Replacement Insurance? ☐Yes ☐No

EMERGENCY CONTACT

Name _____ Phone # _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO ROCKY MOUNTAIN NEUROSURGERY AND/OR LLOYD W. MOBLEY MD FOR THESE SERVICES AND ALL FUTURE CLAIMS. I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. IT IS MY RESPONSIBILITY TO KNOW MY COPAYS, DEDUCTIBLES, COINSURANCE , AND OUT-OF-POCKET AMOUNTS WHICH HAVE BEEN ESTABLISHED THROUGH MY INDIVIDUAL INSURANCE POLICY. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS.

Signature _____ Date _____