



**Is your injury or condition the result of an accident ?** (YES) or (NO)

If "Yes" is it related to: (Circle One)      WORK      AUTO ACCIDENT      OTHER

If "Other", please explain: \_\_\_\_\_

Describe how the injury or condition occurred : \_\_\_\_\_

If work related; employer at the time of the injury: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

.....  
**PRIMARY INSURANCE CARRIER:**

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Group Number: \_\_\_\_\_ ID Number: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

**SECONDARY INSURANCE CARRIER:**

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Group Number: \_\_\_\_\_ ID Number: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

**INDUSTRIAL INFORMATION:**

Carrier Name: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Claims Representative: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

.....  
**INFORMATION MUST BE COMPLETE IN ORDER TO BILL YOUR INSURANCE. IF YOU ARE UNABLE TO PROVIDE THIS INFORMATION YOU MUST PAY FOR ALL SERVICES AND BILL YOUR OWN INSURANCE. CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.**

**ASSIGNMENT OF BENEFITS:**

**I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE DIRECT PAYMENT TO:**  
\_\_\_\_\_  
**M.D., I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY DEDUCTIBLES, CO-INSURANCE AND/OR CO-PAYMENT AMOUNTS.**

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**LOS ANGELES NEUROSURGICAL INSTITUTE  
8670 WILSHIRE BOULEVARD, SUITE 201  
LOS ANGELES, CA 90211  
Phone: 310- 659-6633 Fax: 310-659-6631**

Note to patient: By providing you signature below and marking the appropriate boxes, you are authorizing us to either 1) Obtain films, test results and general information from other medical providers to assist us in evaluating your current condition .2)Release information to your primary care or referring physicians (or other specifically designated person) or both of the above as well, you will be authorizing payment directly to \_\_\_\_\_, M.D. for services rendered and accepting financial responsibility for any service provided, and you will be consenting to any and all medical treatments provided by \_\_\_\_\_, M.D.

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|                     |            |                      |
|---------------------|------------|----------------------|
| <b>Patient Name</b> | <b>SS#</b> | <b>Date of Birth</b> |
|---------------------|------------|----------------------|

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I Authorize physician/staff associated with \_\_\_\_\_, M.D../or Cedars-Sinai Neurofunctional Center to:

- Release information to:
- Obtain information from:

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|                                      |              |            |
|--------------------------------------|--------------|------------|
| <b>PHYSICIAN OR OTHER PARTY NAME</b> | <b>PHONE</b> | <b>FAX</b> |
| <b>ADDRESS</b>                       | <b>CITY</b>  | <b>ZIP</b> |

Information to be released from medical record includes:

- Complete Record
- Other: Please specify \_\_\_\_\_

**FINANCIAL AGREEMENT**

The undersigned hereby authorized \_\_\_\_\_, M.D. otherwise payable to me for services rendered, realizing that I am financially responsible for payment of all services not covered by my insurance.

**CONSENT FOR TREATMENT**

The undersigned hereby authorized \_\_\_\_\_, M.D.. and consents to any x-ray examination, laboratory procedure, and all treatments rendered to me and/or to my child/children named above (when a minor is being treated by \_\_\_\_\_, M.D.). I understand that this authorization shall expire, without my express revocations, 6 months from the date written below.

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|                          |             |
|--------------------------|-------------|
| <b>PATIENT SIGNATURE</b> | <b>DATE</b> |
|--------------------------|-------------|

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|                                       |             |
|---------------------------------------|-------------|
| <b>SIGNATURE OF AUTHORIZED PERSON</b> | <b>DATE</b> |
|---------------------------------------|-------------|

*In the case of a patient who is physically unable to sign this authorization, he/she should place an "X" on the signature line and have his/her assent witnessed.*