 **Carolina Pain & Spine**
an affiliate of MEDNAX
110 Capcom Ave. Suite 200
Wake Forest, N.C. 27587
Phone: (919)229-4046
Fax: (919)562-0020

Patient Information

Name _____ Date of Birth ____/____/____
Address _____ City _____ State _____ Zip _____
Phone (H) _____ (W) _____ (C) _____
E-Mail Address _____
Marital Status: Single ____ Married ____ Widowed ____ Full time Student: Yes ____ No ____
Employer: _____ Occupation: _____
PCP _____ Phone _____
Pharmacy _____ Address _____ Phone _____

Emergency

Emergency Contact _____ Relationship _____
Phone (H) _____ (W) _____ (C) _____

Insurance Information

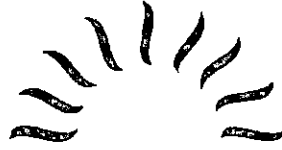
Policy Holder Name _____ Date of Birth ____/____/____
Address _____ City _____ State _____ Zip _____
Insurance Company _____ Member/Subsriber ID _____

Insurance Information-Secondary

Policy Holder Name _____ Date of Birth ____/____/____
Address _____ City _____ State _____ Zip _____
Insurance Company _____ Member/Subsriber ID _____

I certify that the above information is factual and true to the best of my knowledge.
I understand that photo identification, proof of insurance, self-pay payment and/or copay is due at the time of service
I authorize the release of any medical information necessary to process claims.

Signature _____ Date _____



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Notice of Privacy Practices

Patient Acknowledgement Form

Our Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients and 2) how we use and disclose protected health information about our patients.

Federal regulations require that we give our patient and/or their authorized representatives access to our Notice before signing this acknowledgment.

If you have any questions about your rights or our privacy practices, please send an email to: privacy_officer@mednax.com or a letter to:

Privacy Officer
Mednax
1301 Concord Terrace
Sunrise, FL 33323

You are also welcome to address your concerns with our local Practice Manager.

By signing this form, you are only acknowledging that you have been provided the opportunity to review our Notice.

Signature of Patient or Authorized Representative

Date

Print Name of Patient or Authorized Representative

Relationship