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)_____

Medical Insurance Information

Policy Holder Name _____ Date of Birth ____/____/____

Address _____City _____State _____ Zip _____

Insurance Company _____ Member/Subscriber ID _____

Pharmacy Benefits

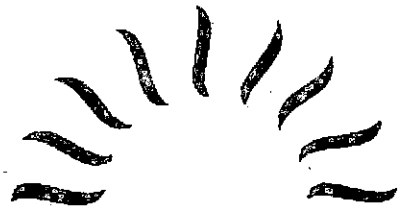
Policy Holder Name _____ Date of Birth ____/____/____

Insurance Company _____ Member/Subscriber ID _____

PCN#_____ RxBin_____ Group #_____

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 _____



Carolina Pain & Spine

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: **Compliance@NAPAAnesthesia.com** or to remain anonymous you can call the Compliance Hotline 24/7 at 800-750-4972

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