

**APPOINTMENT:**

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Office #: \_\_\_\_\_

Chart #: \_\_\_\_\_

**William S. Reid, Jr., M.D.**

Neurological Surgery

Minimally Invasive Spine Surgery

1932 Alcoa Hwy., Suite 280

Knoxville, Tennessee 37920

tnbrainandspine.com

phone (865) 329-4003 fax (865) 329-4043

**PATIENT INFORMATION:**

NAME			SSN
ADDRESS			SEX: Male Female
CITY	STATE	ZIP	DATE OF BIRTH
HOME PHONE:	CELL PHONE:	WORK PHONE:	
MARITAL STATUS: MARRIED SINGLE OTHER: _____			
EMPLOYER'S NAME:		EMPLOYER PHONE #:	
NAME OF PHYSICIAN WHO REFERRED YOU HERE:		NAME OF PRIMARY CARE PHYSICIAN:	
EMERGENCY CONTACT NAME:		PHONE #:	

**INSURANCE INFORMATION:**

PRIMARY INSURANCE	I.D. NUMBER	GROUP NUMBER	POLICY HOLDER'S NAME
POLICY HOLDER SSN#	POLICY HOLDER'S D.O.B.	POLICY HOLDER EMPLOYER	EMPLOYER'S PHONE:
SECONDARY INSURANCE	I.D. NUMBER	GROUP NUMBER	POLICY HOLDER'S NAME
POLICY HOLDER SSN#	POLICY HOLDER'S D.O.B.	POLICY HOLDER EMPLOYER	EMPLOYER'S PHONE:

**ACCIDENT INFORMATION:**

<p>Is your illness the result of an accident? ___ yes ___ no</p> <p>If yes you <u>must</u> contact our office prior to appointment</p> <p>If yes, what type of accident?</p> <p>___ Automobile ___ Work</p> <p>___ Other</p>
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**PLEASE FILL IN ALL BLANKS  
OF THIS FORM,  
FRONT AND BACK**

# William S. Reid, Jr., M.D.

## One Time Authorization Form

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

I request that payment of authorized Medicare and/or other insurance benefits on my behalf to **Dr. William S. Reid** for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the CMS (Centers for Medicare and Medicaid Services) and its agents any information needed to determine these benefits or the benefits payable for related services.

I also understand that I am responsible for my bill at **Dr. William S. Reid**. If I expect any portion of my bill for the services rendered to be paid by insurance or a prepaid health plan, it is my responsibility to notify my physician of what the insurance carrier/carriers requires. I authorize release of information on my care to my insurance company/companies, and I authorize all companies to make payment directly to **Dr. William S. Reid**. I authorize my physician to act as my agent to help me obtain required pre-certification as well as acting as my agent to help obtain payment from my insurance company/companies. I authorize my insurance company/companies to give my physician or my physician assistant any information they require to fulfill this function. I understand that I am responsible for clerical fees for additional insurance forms, disability forms, or statements in excess of what is normally provided. My signature below confirms that authority and may also be utilized to request additional medical information from any hospital or practitioner who has provided care for me.

Your initials: \_\_\_\_\_

**Acknowledgment of Receipt of Privacy Notice:** I acknowledge the PROVIDER'S notice of privacy policies. I consent to the PROVIDER'S use of protected health information as described in the notice for treatment, payment or health care operations. I understand that I must provide a separate authorization before any other disclosures may be made.

Your Initials: \_\_\_\_\_

**Authorization for Release:** By signing below I am authorizing the practice to disclose my protected health information about my current health condition to the following:

Spouse     Parents     Children     Clergy     Other (list names)

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I understand my right and how to revoke this permission as described in the Notice of Privacy Practices.

Your Initials: \_\_\_\_\_

**Request for Restrictions:** I request that my protected health information not be disclosed to the following:

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_