Patient Information

Today's Date _____

Have you been seen by any doctor in our practice before? Yes ☐ No ☐
Which doctor referred you to this office today? _____

Patient _____ ☐ M ☐ F Age___ Date of Birth_____
Legal last name first M.I.

Mailing Address_____
Street City State Zip code

Home phone _____ Cell _____ Soc Sec #_____
*Email address:*_____
Preferred method of contact (mark at least one): ☐ Home phone ☐ Cell phone ☐ Email
Employed by_____ Occupation_____
Marital Status: ☐ M ☐ S ☐ D ☐ W spouse_____ Phone_____
Ethnicity _____ Preferred Language _____

Person Responsible for Payment (If patient, write "self;" if student, write parent's name and address)

Name_____ Relationship to Patient_____
Last First M.I.

Address_____
Street City State Zip code

Phone _____Cell _____ Business phone _____

Soc Sec #_____ Occupation_____ Employer_____

Employer's Address_____

Person to Notify in Case of Emergency (Other than person listed above)

Name_____ Relationship_____ Phone _____

Referred to this office by_____

Insurance Information (please present most recent insurance card at time of check in)

→ **Primary Insurance** _____ PPO ☐ HMO ☐ OTHER ☐
Policy holder's name _____ **Policy holder's DOB:** _____
Policy # _____ Group_____ Phone _____
Address_____

→**Secondary Insurance** _____ PPO ☐ HMO ☐ OTHER ☐
Policy holder's name _____ **Policy holder's DOB:** _____
Policy # _____ Group_____ Phone _____
Address_____

☐ **Work Comp**_____ Have you notified your employer? Y ☐ N ☐
Claim Number:_____ Date of Injury _____

☐ **Auto Injury** - State:_____ Claim Number:_____ Date of accident:_____

☐ Auto and W.C.: Adjustor/case manager's name & phone _____
Billing Address_____

Briefly describe how this accident/injury occurred _____
_____Date of Injury _____

Attorney involved: Name _____ Phone _____
Address_____ (GO TO PAGE 2)

Authorization for Treatment, Financial Agreement and Disclosures

A. INSURANCE POLICY
   1. We will be happy to bill your insurance company if you will supply us with the appropriate information. Please keep us informed of any changes to your insurance information.
   2. If your insurance requires a referral to see a specialist, it is **your responsibility** to make sure a referral is in place before your appointment.
   3. We participate in a number of HMO/PPO organizations. Please check with us or your insurance company to see if we are a participating provider before scheduling your appointment.
   4. In the case of divorce, the parent bringing the child in for treatment will be responsible for payment. We will file any insurance claims for you, provided we have received the appropriate information from you.

B. Payment Policy
   1. Payment is due and payable at the time of each service.
   2. We accept cash, checks, Visa, Master Card, and Discover
   3. All co-pays are due at the time of service.
   4. If there is no payment or notice from your insurance company within 90 days of the date of service, the balance will become your responsibility.
   5. Our fees are generally considered to fall within the acceptable range by most companies and, therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage of usual, customary and reasonable fees for the region. Thus, our fees are considered usual, customary and reasonable by most companies.
   6. Not all services are a covered benefit in all contracts. Some insurance companies may select certain services they will not cover.

C. Fees
   1. We charge a $50 administrative fee for all no-show appointments.
   2. Our charges for service, including office visits and surgery, are based upon the severity and complexity of your injury or illness as well as the time spent treating you. Please do not hesitate to inquire about the charges for our services.

D. Statements
   1. A statement of fees is sent to you regularly. Our office relies on you for settling your account. You are ultimately responsible for all office and surgery fees relating to your care. Your health policy is an agreement between you and your health insurance carrier. If you need to make special arrangement for payment, please contact our billing office.
   2. As a last step in collecting overdue accounts, we do participate with a collection service agency. Any account with no payments or contact from the patient within 90 days of the day of service will be turned over to this company.

E. Medicare
   1. We do accept assignment on your Medicare charges. Medicare pays our office directly.
   2. You will receive a statement each month to let you know the status of your account.
   3. We will be happy to bill a secondary insurance company if you will supply us with the appropriate information.

RELEASE OF INFORMATION AND DISCLOSURES

I hereby authorize direct payment of medical benefits to Colorado Spine Institute, PLLC. My signature below also authorizes this office to release medical information to assist with any outstanding balances on my account. This will be considered a life time signature for all Medicare patients.

Some physicians at this facility have financial interests in other medical services to enable us to provide the highest quality control to our patients. These interests may include: Arête Surgical Center, Spinal Solutions, Colorado Spine Institute, pharmaceuticals, medical supplies and implants.

Patient Signature _____ Date _____