Spine Care Specialists

PATIENT INFORMATION Date_____

NAME: Last _____ First _____ M.I. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: M____ F____ Age: ____ D.O.B._____ Soc. Sec. #_____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone:(____)_____ E-mail address_____

Employer:_____ Occupation: _____

Primary Care Physician: _____ Phone (____) _____

Address: _____

Referring Physician: _____ Phone (____)_____

Address: _____

In case of emergency, please notify: _____ Phone: (____)_____

Relationship: _____

PRIMARY INSURANCE

Name: _____ I.D.# _____ Group#_____

Card Holder's Name: _____ Relationship_____

Card Holder's SS#_____ D.O.B_____

Submit claims to (address): _____

Insurance Company Phone (____)_____ Employer:_____

Employer Phone (____)_____ Effective Date of Policy: _____

ADDITIONAL INSURANCE

Name: _____ I.D.# _____ Group#_____

Card Holder's Name: _____Relationship._____

Card Holder's SS#:_____D.O.B._____

Submit claims to (address): _____

Insurance Company Phone (____)_____ Employer:_____

Employer Phone (____)_____ Effective Date of Policy: _____

(See reverse side)

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with (name of insurance company) _____ _____ and assign directly of Spine Care Specialists all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/ Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to providers of Spine Care Specialists for any services furnished by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated on the Patient Registration form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are bases upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

BWC INFORMATION

Claim # _____ Date of Injury _____

Allowable diagnosis (es) _____

Employer _____ Employer Phone Number _____

Employer Address _____

Attorney Name _____ Atty Phone _____

MCO Name _____ MCO Phone _____

MCO Fax Number _____ Case Manager _____

MCO Address _____

This must be completed in full in order to process billing for the patient. Without this information the patient may be responsible for services. It is the patient's responsibility to provide this information to the provider(s) of Spine Care Specialists. If unsure about the above information you must contact your employer immediately for the information and provide it to Spine Care Specialists to ensure timely filing of your claim.