

Policy Holder Name _____ Birth Date _____ ID# _____ Group # _____

Effective Date _____ Relationship to Patient _____

Healthcare Reform Questions: Due to recent reforms mandated by the government American Recovery Reinvest Act (ARRA) legislation, doctors are required to ask all patients for their race and ethnicity regardless of insurance to meet Meaningful Use Requirements.

Ethnicity: (check one) Hispanic or Latino Non-Hispanic Declined to Report

Primary Race: (check one) American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or other Pacific Islander White Unsure or Declined to Report

Language: (check one) English Spanish Arabic Chinese French German
 Japanese Russian Vietnamese Other

Please state your reason for today's visit: _____

Is this an on the job or other work related injury? Yes No

If so, please complete the following:

Employer Name: _____ Phone _____

Case Worker's Name _____ Case Worker's Phone _____

Date of Injury _____

Is this an injury from a Slip and Fall or Auto related injury? Yes No

Date of Injury _____ Attorneys Name _____ Phone _____

Insurance Information

The specialty of pain management requires additional paper work for your insurance company. Please be aware that you may receive forms in the mail from your insurance company requesting:

- Accident information
- Coordination of Insurance Benefits Information

Please respond immediately to your insurance.

If you do not respond to the insurance company within 30 days, they will delay your case and will not pay any claims. You will end up responsible for 100% of billed charges and will have no recourse to appeal.

Financial Policy and Assignment of Benefits

***Payments for medical services rendered are due at the time of service unless prior arrangements have been made.**

Our office verifies eligibility and benefits with your health insurance company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your status. We will do all we can to assist you with your insurance claims; however, the insurance is a contract between you and your insurance carrier. Final responsibility for payment of your account rests with you.

Prior authorizations obtained for procedures by this office on your behalf do not guarantee payment but rather are based on medical necessity. Claims are subject to policy provisions, and your insurance carrier determines final payment. A deposit is required if you are being scheduled for a procedure.

Having read the above, I hereby authorize payment by my insurance carrier, Medicare, Medicaid, or other designated payers of medical benefits to Spine LLC for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A photocopy of the assignment is considered as valid as the original.

I also authorize Spine LLC to release to my insurance carrier or their agents any medical information about me needed to determine these benefits payable for service.

I understand that if my account becomes delinquent and is assigned to an outside collection agency, that an additional mark up of 100% will be added to the amount I owe. I understand the adding of this collection fee as well as the accrual of interest at the statutory rate should by account be assigned to a collection agency. I agree to pay Spine LLC for the medical services provided, collection fees if added and interest.

I hereby consent to and authorize medical treatment, tests, and procedures performed in this office that my physician deems advisable and necessary based on his judgment. I understand that I may ask whatever questions needed to understand the necessity for and expected outcomes of the recommended care.

I have read and understand the above statements:

Patient Signature

Date

Please Print Your Name