



FIRST NAME

MIDDLE

LAST

ADDRESS

CITY

STATE

ZIP

HOME PHONE _____ CELL _____ FAX _____

WORK _____ EMAIL _____

SOCIAL SECURITY _____ DOB _____ MARITAL STATUS _____

INSURED'S NAME _____ DOB _____ ADDRESS _____

EMERGENCY

CONTACT _____ PHONE _____ RELATIONSHIP _____

OCCUPATION _____ EMPLOYER _____

IF RETIRED, PREVIOUS OCCUPATION _____

MEDICARE # _____

SECONDARY INSURANCE CO _____ # _____

INJURY AREA _____ DATE OF ONSET _____

HOSPITALIZED FOR THIS CONDITION? YES NO DATES _____ SURGERY _____

HAVE YOU RECEIVED HOME HEALTH SERVICES IN THE LAST 3 MONTHS? YES NO

IF YES, DATE YOUR WERE LAST SEEN _____ DATE DISCHARGED _____

NAME OF HOME HEALTH FACILITY _____

HAVE YOU HAD PHYSICAL THERAPY THIS YEAR? FACILITY _____

HOW MUCH OF THE MEDICARE CAP HAS BEEN USED THIS YEAR? __\$ _____

HOW DID YOU HEAR OF SPINE & SPORT INSTITUTE? _____

PAYMENT AGREEMENT

I understand that my insurance policy is a legal agreement between the insurance company and myself. I agree to pay all deductibles, co-payments, co-insurances, and balances according to this legal agreement at the time the services are rendered or, for Medicare, within 30 days of the Medicare Advice Remission. Any balance the insurance company, including Medicare secondary insurance, has not paid 30 days following submission, is then due and payable by me.. Where insurance coverage is not involved (self-pay, unauthorized Worker's Compensation, Medicare waivers [non-medical necessity]), full payment is due and payable at the time the services are rendered. My financial responsibility is in no way altered or affected by the outcome or my satisfaction of the interventions with this facility. I acknowledge and agree that I am ultimately responsible to Spine & Sport Institute for any outstanding balance, including unpaid deductible, unpaid percentage amounts, insurance non-coverage/denials, denied legal claims, Auto/PIP claims, and for any difference in the cost from the carrier's 'usual and customary' fee structure, except for our contracted insurance with Medicare.

Patient/Responsible Party

Date

AUTHORIZATION TO FILE BENEFITS/ASSIGNMENT

I authorize payment of Medicare and/or insurance benefits to Spine & Sport Institute for services rendered. I certify that any information given by me regarding my insurance is correct, and allow the release of any information necessary for insurance filing I acknowledge the assignment of benefits.

Patient/Responsible Party

Date

AUTHORIZATION OF RELEASE OF INFORMATION

I authorize Spine & Sport Institute to release to any insurance carriers/Workers Compensation/local assistance agencies, and information necessary to substantiate a claim. I also authorize Spine & Sport Institute to request information deemed necessary to assist in my treatment and claim documentation. I agree a copy of this authorization shall be as valid as the original.

Patient/Responsible Party

Date

CONSENT FOR EVALUATION

I willingly choose to be evaluated at Spine & Sport Institute. I understand there are inherent risks in the evaluative process, including an increase in my level of pain. If I choose to return for treatment, consent for treatment is understood. Whether or not I return for treatment, I am responsible for the charge for the evaluation.

Patient/Responsible Party

Date

MISSED APPOINTMENT POLICY

We sincerely wish we did not have to charge for a last minute cancelation, however we require a \$50.00 payment when a visit is canceled with less than 24 hours' notice. The fee is progressively increased with repeated occurrences. ¹ The first No Show appointment charge is \$75.00. ²

We schedule extensive, one on one treatment time with you and we do not double-book. A missed appointment is not only valuable time your therapist has saved for you, but without sufficient notification we are unable to arrange treatment for another patient who may be in great need. We respect your time and ask that you respect ours and the needs of other patients.

Speaking of time, it is our sincere intention to start your treatment on time. We do ask that if you find you are waiting more than 5 minutes beyond your appointment time to please alert Laurie at the Front desk or a therapist. If we are running late it is because of an unavoidable delay in treating a previous patient and trying to meet 100% of their needs that day. Please know we will provide you with the same effort and your complete treatment.

1. First late Cancellation is \$50.00 and each late cancellation thereafter will increase by \$25.00 each. (Your 4th late cancellation will be \$125.00; After 4 late cancellations continued appointments will need to be redetermined.)

2. The first No Show is \$75.00 and the second is \$125.00. After two No Show appointments further appointments will need special arrangements.

I have read, understand and agree to abide by the late cancellation and the No Show policies. My intention is to keep my appointments and to advise the clinic of any changes in my schedule as soon as possible.

Signature

Date

*Please note appointments for Mondays need to be Canceled by 4:45 PM on the preceding Friday

^ The second late cancelation fee is \$75 and the third is \$100. If there is a second No Show appointment the charge is \$100.