FIRST NAME MIDDLE LAST

ADDRESS CITY STATE ZIP

HOME PHONE_____ CELL_____ FAX_____

WORK_____ EMAIL_____

SOCIAL SECURITY_____ DOB_____ MARITAL STATUS_____

EMERGENCY
CONTACT_____PHONE_____RELATIONSHIP_____

WORKMAN'S COMPENSATION INFORMATION

OCCUPATION_____EMPLOYER_____

ADDRESS_____PHONE_____

WORKMAN'S COMP OFFICIAL CONTACT_____

PHONE_____ FAX_____EMAIL_____

PHYSICIAN_____ PHONE_____FAX_____

AUTHORIZATION DATE FOR PHYSICAL THERAPY_____ VISIT #_____

INJURY AREA/CHIEF COMPLAINT_____

_____

DATE OF INJURY_____ PREVIOUS THERAPY _____

SIGNATURE_____

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.