CENTER FOR SPINE PROCEDURES

PATIENT INFORMATION SHEET

Name: _____ Date: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Cell Phone: _____

Zip: _____ Sex: ○ Male ○ Female Soc Security # Date of Birth: _____ Age: _____

Email address: _____ Race: ○ Caucasian ○ Black ○ Hispanic ○ Other

Patient's Employer: _____ Occupation: _____

Employer's Address: _____

City: _____State: _____ Zip_____ Work Phone: _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed Spouse's Name: _____ DOB _____

EMERGENCY Contact: _____ Phone: _____

Patient Primary Care Physician: _____ Phone: _____

Party responsible for account (If Work Comp or Auto provide that information)

Name: _____ Relationship to patient: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ DOB: _____

Responsible person's employer: _____ Phone: _____

City: _____ State: _____ Zip: _____

Primary Insurance: _____ Phone: _____

ID # _____ Group # _____

Additional Insurance

Subscriber Name: _____ Date of Birth: _____

Insurance Company: _____ Phone: _____

ID # _____ Group # _____

City: _____ State: _____ Zip: _____

Attorney's name (if applicable) _____ Phone: _____

Major credit card type and number: _____ Exp. Date: _____

There may be instances that your health care provider may wish to communicate some aspects of your protected health information and or account information via electronic means, either to you and/or another health care provider that may be consulted regarding your care or treatment. Non-Surgical Orthopaedics, PC cannot guarantee privacy for e-mail communications over the Internet. I understand and accept this risk, and will allow Non-Surgical Orthopaedics, PC to communicate my information electronically. ○ Yes ○ No

By my signature below, I hereby specifically authorize the physician and/or his agents to provide medical treatment to me. I also authorize Non-Surgical Orthopaedics, P.C. (NSO) and The Center for Spine Procedures, P. C. (CSP) to release any medical and personal information acquired in the course of treatment that is necessary to process insurance claims, or receive payment from any payment entity and authorize my insurance company to make the payments for my medical services directly to the physician, realizing that I am responsible for any amount not covered/paid by my insurance. I acknowledge that I understand by the policies of the practice of NSO as read in the Practice Handbook, and will be bound by the provisions contained in the Handbook. I also authorize the practice to release any medical information or insurance information that requested by any physical therapy, diagnostic imaging or clinical research facility that the practice refers me to as part of my treatment.

Patient (Guardian) Signature: _____ Date: _____

Appointment Cancellation Policy

Non-Surgical Orthopaedics, P.C. and Center for Spine Procedures, P.C. requires a 24-hour notice for cancellation of appointments. We reserve the right to charge a $25.00 fee for appointments that are cancelled without a 24-hour notice, or if a patient does not show up for their scheduled appointment.

If the appointment was for an injection procedure in the Center for Spine Procedures, P.C., the fee is $200. This fee is your responsibility and will not be billed to your insurance company.

It is the responsibility of you, the patient, to provide us with your current address, telephone numbers, and insurance information at the time of your initial visit and any other visits thereafter. In addition, it is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan.

You are ultimately responsible for payment of services rendered from our office, and copays, deductibles, balances, etc. must be paid prior to seeing the physician or we may have to reschedule your appointment. There is a $35.00 returned check fee for checks not honored by the bank.

Your signature below is required and is proof that you acknowledge the Appointment Cancellation Policy set in place by Non-Surgical Orthopaedics, P.C. and acknowledge that you will be responsible for payment of a cancelled or missed appointment.

_____
Please Print Name

_____ _____
Patient Signature Date

Print Form Clear Form Save Form Submit Form