

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, including changes to office visit (\$75) or procedure (\$220) no-show or late cancellation fees. 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 the Center for Spine Procedures, P.C. requires a 24 hour notice for cancellation of appointments. We reserve the right to charge a \$75.00 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 less than 24 hour cancellation fee or no show fee is \$220.

You will also be charged a \$45.00 Late Fee if you are more than 15 minutes late to your appointment. 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 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, co-insurances, balances, etc. must be paid prior to seeing the physician or we may have to reschedule your appointment. There is a \$60.00 returned check fee for checks not honored by the bank.

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

Print Name

Patient Signature

Date