REHABILITATION, SPORTS & SPINE CENTER, P.S.

Patient Last Name _____ First Name _____ __ _MI _____

Address _____City _____State _____ Zip_ _____

Home Phone: (____)_____Work/Cell(____)_____E mail:_____

Date of Birth _____ Sex: _____ Employer: _____

Social Security Number (required to bill Medicare and Tricare) _____

Primary Care Physician _____Referred by_____

PRIMARY INSURANCE_____

Subscriber ID _____ _____Group #_____ Sex _____

Relation to subscriber: Self _____ Spouse_____ Parent/Guardian_____ Other_____

SECONDARY INSURANCE _____

Subscriber_____ Employer_____ Birthdate _____

Subscriber ID _____ Group _____ Sex _____

Relation to subscriber: Self _____ Spouse_____ Parent/Guardian_____ Other_____

L&I: Claim # _____ Date of Injury_____ Claims Manager: _____Phone _____

Employer of Injury: _____ Self Insured Company: _____ _____

MVA: Ins Co: _____Address: _____

Date of Accident_____ Claims Adjuster _____Phone _____
**********Please note we do not hold claims until settlement.

Responsible Party: Who is responsible for any remaining balance on this account?

Self_____Parent/Guardian_____Name_____Phone_____

Emergency Contact _____Phone: _____Relationship_____

We consider all patients as private pay unless we are contracted with your insurance company. If your insurance information or other documents needed are not provided prior to your first visit, all charges will be your responsibility. It is your responsibility to see that your health plan requirements are met, including referrals, pre-authorizations and pre-certifications. With my signature, I acknowledge that I have read the above statement and agree to pay any charges that my insurance does not cover, including services incurred that my insurance company deems "medically unnecessary" or "pre-existing". In addition, I authorize my insurance company to make payment directly to my physician, and I authorize the physician to release any information to my insurance companies as required to process my claims, and to other health care providers for the purposes of continuing care.

Patient Signature: _____ Date: _____