SPINE MIDWEST, INC   PATIENT INFORMATION FORM

PATIENT NAME________________________________ **EMAIL:**____

ADDRESS____
STREET/P O BOX   CITY   STATE   ZIP

IS THIS VISIT RELATED TO A MOTOR VEHICLE ACCIDENT (mva) :____YES____NO
OR A WORK RELATED INJURY:____YES____NO

IF YOU ANSWERED YES TO EITHER OF THE ABOVE QUESTIONS PLEASE SEE RECEPTIONIST PRIOR TO COMPLETING REST OF FORM

SOCIAL SECURITY#____DATE OF BIRTH_________________________
Minors must be accompanied by an adult

SEX________MARITAL STATUS _______ PRIMARY CARE/FAMILY PHYSICIAN:_________________________________

HOME PHONE_________________________WORK________________________CELL______________________________

EMPLOYED BY____OCCUPATION__________________________

ALTERNATE CONTACT NAME___________________________________RELATIONSHIP TO PT____________________

HOME PHONE_________________________WORK________________________CELL______________________________

BILL TO INFORMATION:

NAME____RELATIONSHIP TO PATIENT______________________

ADDRESS____
STREET/P O BOX   CITY   STATE   ZIP

SOCIAL SECURITY#____DATE OF BIRTH_________________________

HOME PHONE_________________________WORK________________________CELL______________________________

EMPLOYED BY____OCCUPATION__________________________

INSURANCE PRIMARY____

INSURANCE SECONDARY____

All patients must complete this form in its entirety prior to being seen by the physician

I, the undersigned, hereby authorize the physicians of Spine Midwest, Inc to examine and to administer such treatment as is necessary and to perform such procedures as are considered therapeutically or diagnostically necessary. I agree that any non personalized medical outcome data may be utilized in the ongoing evaluation and knowledge dissemination of such treatments. All treatments will be discussed prior to administration.

Signature of patient or legal representative____

Date of authorization______________________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

The patient/responsible party who requests treatment and/or services is responsible for all associated fees at the time service is rendered; unless Spine Midwest, Inc participates in the insurance plan given. If your insurance plan is one with which we participate, we will submit to your insurance company any physician office and physician associated hospital charges. We file the insurance as a courtesy to our patients and if your insurance plan is one with which we do not participate we can file the claim with the understanding that in doing so it could result in greater out of pocket expense to the insured.
Insurance is a contract between the subscriber and the insurance company, typically we are not party to that contract therefore Spine Midwest, Inc will not become involved in disputes between you and your insurance regarding co-payments, deductible or other matters regarding reimbursement.

By signing below you authorize Spine Midwest, Inc to release to the insurance company any information needed for this claim or related Medicare claims and that payment under the medical insurance program be made to the provider named on any bills for services rendered during the course of your treatment with Spine Midwest, Inc.

SPINE MIDWEST INC WILL NOT bill for cases under litigation or involving a third party payer regardless of legal actions pending, motor vehicle insurance, disputed injuries or custody cases. Payment is expected at time of service.

There has been a continual increase in insurance companies requiring pre-certification or prior authorizations for hospitalization and outpatient, diagnostic procedures. It is the **subscriber's responsibility** to be aware of the requirements of their insurance company and alert us prior to any l services being rendered. Failure to do so may result in partial or complete denial of benefits by the insurance company subsequently non-paid services will become the financial responsibility of the subscriber/patient.

We are committed to providing the best possible care for our patients and are pleased to discuss our professional fees at any time. The fees vary with the nature of the visit and are based on services rendered by the physician or staff. Please note that we do utilize Physician Assistants at Spine Midwest and that additional charges for his/her services may apply.

Thank you for your compliance with our financial policy. Please let us know if you have any questions regarding this policy or your responsibility.

Signature of patient or legal representative____

Date of authorization_________________________