

SPINE AND REHABILITATION CENTER - New Patient Information Sheet

Today's Date: _____ Referring Physician: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: M F Marital Status: Single Married Divorced Separated

Patient Home Phone #: _____ Spouse/Nearest Relative: _____ Phone #: _____

Emergency Contact Person: _____ Emergency Contact Phone #: _____

Patient Social Security #: _____ Employer: _____

Employer Address (Street, City, State, Zip): _____

Work Phone #: _____ Driver's License #: _____ Patient Occupation: _____

Email address: _____ Patient Cell #: _____

Family Physician (if different than referring physician): _____

Injury? => Date of Injury: _____ Workers' Comp Auto Accident Slip and Fall Other

Do you have an attorney for this injury? N Y If yes => Name: _____ Phone #: _____

Policy Holder's Name: _____ Policy Holder's SS#: _____

Family Physician (if different than referring physician): _____

GUARANTOR INFORMATION (person responsible for payment other than insurance company)

Check here if the guarantor is the patient Patient Relationship to Guarantor: _____

Name: _____ Address: _____

City, State, Zip: _____ Home Phone #: _____ Work Phone #: _____

Employer: _____ Employer Address: _____

Guarantor Social Security #: _____ Guarantor Date of Birth: _____

AUTHORIZATION, FINANCIAL RESPONSIBILITY, AND CONSENT TO TREAT

I authorize SRC to release or obtain my medical information to any insurance company, attorney, insurance adjuster, employer or their representative as may be necessary in the treatment and payment of my care.

I understand payment is due in full at the time of services, unless special payment plan arrangements have been made with my insurance carrier. I understand that there will be a \$30.00 services charge on all returned checks. I understand I will be responsible for a \$40.00 fee for failure to keep any scheduled appointment without prior notification. I understand that if my health insurance is not contracted with SRC, then I assign my health insurance benefit, my personal injury protection benefit, and my medical payment benefit to SRC as needed to pay my bill for services rendered.

I consent to all necessary examination procedures and/or treatments prescribed by my physician, physician assistant, chiropractor, or physical therapist, his/her assistants, or designees as is necessary in his/her judgment.

SIGNED (Patient or Guardian)

DATE

The Spine and Rehabilitation Center
Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by The Spine and Rehabilitation Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of The Spine and Rehabilitation Center. I understand that diagnosis or treatment of me by any and or all of the providers at the Spine and Rehabilitation Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Spine and Rehabilitation Center is not required to agree to the restrictions that I may request. However, if The Spine and Rehabilitation Center agrees to a restriction that I request, the restriction is binding on The Spine and Rehabilitation Center and its providers.

I understand that my treatment may include therapy services in an open Gym/treatment area and that all efforts will be made to provide treatment in the most private manner possible.

I have the right to revoke this consent, in writing, at any time, except to the extent that the treating provider or The Spine and Rehabilitation Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my provider, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand that during the course of daily healthcare operations, my "protected health information" may be indirectly disclosed to a third party who overhears a discussion regarding your information. I understand and agree that this is not a breach of my "protected health information."

I understand I have a right to review The Spine and Rehabilitation Center's Notice of Privacy Practices prior to signing this document. The Spine and Rehabilitation Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of The Spine and Rehabilitation Center. The Notice of Privacy Practices for The Spine and Rehabilitation Center is also posted in the lobby of all clinics. This Notice of Privacy Practices also describes my rights and The Spine and Rehabilitation Center's duties with respect to my protected health information.

The Spine and Rehabilitation Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority