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 Twin Falls, Idaho 83301

New
 Change

DATE / /		PATIENT INFORMATION				ACCOUNT #:
PATIENT'S FULL NAME (please print) (Last, First, Middle Initial)					MAIDEN	NICKNAME?
ADDRESS		CITY & STATE	ZIP CODE	HOME PHONE ()		
SOCIAL SECURITY NO.	MARITAL STATUS		SEX	BIRTHDATE	AGE	
	S	M	M	F	/	/
PATIENT'S EMPLOYER			OCCUPATION (or none, homemaker, retired, student, etc.)			DATE OF RETIREMENT
EMPLOYER ADDRESS				WORK PHONE ()		
EMERGENCY NOTIFICATION (Name, Address of Person to Contact)			RELATIONSHIP	PHONE ()		
SPOUSE'S NAME			SOCIAL SECURITY NO.		BIRTHDATE	
ADDRESS (if different from Patient)		EMPLOYER			WORK PHONE ()	
RESPONSIBLE PARTY (if different from Patient)		RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other:		HOME PHONE ()		
ADDRESS			EMPLOYER			
INSURANCE INFORMATION (Please print information about the patient's insurance here)						
<input type="checkbox"/> NO INSURANCE COVERAGE		Is your visit result of accident? YES <input type="checkbox"/> NO <input type="checkbox"/> Date of Injury: / /				
Have you applied for Medicaid? YES / NO		Is this a Workers Compensation claim? YES <input type="checkbox"/> NO <input type="checkbox"/> Claim #:				
PRIMARY INSURANCE COMPANY			SECONDARY INSURANCE COMPANY			
INSURANCE COMPANY'S ADDRESS			INSURANCE COMPANY'S ADDRESS			
CITY	STATE	ZIP	CITY	STATE	ZIP	
GROUP PLAN NUMBER		SUBSCRIBER NUMBER		GROUP PLAN NUMBER		
PRIMARY POLICY HOLDER'S NAME (First, Middle Initial, Last)			DATE OF BIRTH MONTH DAY YEAR		SECONDARY POLICY HOLDER'S NAME (First, Middle Initial, Last)	
					DATE OF BIRTH MONTH DAY YEAR	
Please present ALL Insurance Cards and any authorization or referral documents to receptionist with this form.						
WHO REFERRED YOU TO OUR PRACTICE? Physician <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Newspaper <input type="checkbox"/> Radio <input type="checkbox"/> TV <input type="checkbox"/> Family/Friend <input type="checkbox"/> E/R <input type="checkbox"/> Web Page <input type="checkbox"/> Chiropractor/Physical Therapy <input type="checkbox"/> Other <input type="checkbox"/>				ADDRESS		
PHYSICIAN NAME:				PHONE		
WHO IS YOUR REGULAR FAMILY PHYSICIAN?			ADDRESS		PHONE	
AUTHORIZATION AND ASSIGNMENT						
Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.						
If your insurance has not paid your account in full within 45 days of billing, we will require the balance to be paid by you. We accept cash, check, Visa, Master Card and Discover. PAYMENT IS DUE IN FULL AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS ARE MADE THROUGH OUR BUSINESS OFFICE.						
If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.						
I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including medicare, private insurance and other health plans to Spine Institute of Idaho.						
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.						
I hereby authorize the practice to appeal any incorrect insurance payment. I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN ABOVE.						
X _____						Date _____