

PLEASE PRINT

(For Office Use Only)

Patient Chart No: _____ Date: _____

PATIENT INFORMATION

Today's Date: _____ *(Must give full legal name)*

Last Name: _____

First: _____

Middle: _____

Titles, i.e. M.D., PhD, Jr., Sr., II, etc.: _____

SSN #: _____ / _____ / _____ Date of Birth: _____ / _____ / _____

Sex: Male Female

Marital Status: Single Married Widowed Separated Divorced

Patients' Mailing Address

Street: _____

City: _____

State: _____ Zip: _____ - _____

Home Phone: (____) _____ / _____

Work Phone: (____) _____ / _____ Ext: _____

Cell Phone: (____) _____ / _____

Email: _____

Employer Information

Patient Employer: _____

Employers' Address: _____

Responsible Party: Self Parent

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: (____) _____ - _____

Cell Phone: (____) _____ - _____

Relationship if not parent: _____

Referral Information - I was referred by:

Self

If Self, how did you hear about us? (ex. website etc): _____

Friend

Primary care/family physician.

Physician other than my primary care/family physician.

Referring Physician Information:

First and Last Name Please: _____

City & State Please: _____

Office Phone: (____) _____ - _____

For Office Use Only:

NPI: _____

Primary Insurance Company

Insurance Company Name: _____

ID#: _____ Group#: _____

Claims Address: _____

Policy Holder's Name: _____

Policy Holders' Date of Birth: _____ / _____ / _____

Policy Holders' Social Security Number: _____ / _____ / _____

This health insurance plan is through my employer

Secondary Insurance Company

Insurance Company Name: _____

ID#: _____ Group#: _____

Claims Address: _____

Policy Holder's Name: _____

Policy Holders' Date of Birth: _____ / _____ / _____

Policy Holders' Social Security Number: _____ / _____ / _____

This health insurance plan is through my employer

Worker's Compensation Information

My case is *open and covered* by WORKER'S COMP:

YES NO

My date of injury is:

Month: _____ / Day _____ / Year _____

Other:

Is this injury the result of a motor vehicle accident?

YES NO

Date of Motor Vehicle Accident:

Month: _____ / Day _____ / Year _____

Emergency Contact:

Name: _____

Relationship: _____

Home Phone: (____) _____ / _____

Work Phone: (____) _____ / _____ Ext: _____

Cell Phone: (____) _____ / _____

Other: _____

Complete the information below:

Third or Additional Insurance

Insurance Company Name: _____

ID#: _____ Group#: _____

Claims Address: _____

Policy Holder's Name: _____

Policy Holders' Date of Birth: _____ / _____ / _____ Policy Holders' Social Security Number: _____ / _____ / _____

This health insurance plan is through my employer

MEDICARE AND MEDICAID PATIENTS

I authorize TSBCC to release to the Social Security Administration or its intermediaries or agencies processing Medicaid claims, any medical or other information needed for processing of this and any related claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Triangle Spine and Back Care Center agrees to accept the payment determination of the Medicare intermediary as the full charge for covered services. However, I am responsible for any deductible, co-payment and non-covered services under the Medicare program.

Patient Signature: _____ **Date:** _____

OTHER INSURANCE

I authorize the release of medical information necessary for claims processing to health insurance companies and worker's compensation carriers. I request that payment of insurance benefits be made to the party of accepting assignment of benefits. I understand and acknowledge that I am responsible for payment of any deductible, co-payment, or non-covered services.

THIS OFFICE DOES NOT FILE THIRD-PARTY INSURANCE CLAIMS.

Patient Signature: _____ **Date:** _____

CANCELLATION POLICY

It is important to us to maintain quality and consistency of care for all of our patients. Due to a recent increase in missed appointments, we have implemented the following cancellation policy:

- It is important for you to come to all of your appointments as they are scheduled for consistency of care.
- In the event that you need to cancel an appointment, please call at least 24 hours in advance to notify us.
- There will be a \$50 cancellation fee for all missed appointments with less than 24-hour notice.
- We are unable to continue to reschedule visits for anyone who has missed 2 appointments without at least 24 hours notice.
- Emergency situations and sickness will be considered on a case-by-case basis.

Advanced notice of cancellations helps us to maintain consistency of care as well as offer appointment times to other patients. Thank you for your understanding and cooperation.

Patient Signature: _____ **Date:** _____