

Frederick Sport and Spine Clinic, Inc.



PATIENT INFORMATION

Patient's Full Name:		
Birth Date: / /	Age:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M
Street Address, (P.O. Box is not acceptable):		
City/State:	Zip Code:	
Social Security Number: - -		
Driver's License Number:		
Home Tel. #: ()		
Alternate Tel. #: ()		
Guarantor's Full Name (if different from patient):		
Guarantor's Birth Date: / /		
Guarantor's Social Security Number: - -		
Guarantor's Street Address:		
Guarantor's Tel. #: ()		
Spouse's Full Name:		
Spouse's Birth Date: / /		
Spouse's Social Security Number: - -		
Spouse's Employer and Address:		
Spouse's Work Tel. #: ()		
Emergency Contact Name:	Tel. #: ()	
Additional Contact Name (other than spouse):	Tel. #: ()	
Patient's Employer:		
How long at present employer?:		
Position Title:	Work Tel. #: ()	
Employer Address:		
City/State:	Zip:	

INSURANCE INFORMATION

Do you have Insurance?	
Primary Insurance Carrier:	
Name of Subscriber:	DOB:
Policy #:	Group#:
Employer:	

Are your symptoms a result of an occurrence at work ? Y N
 Are your symptoms a result of an automotive incident? Y N _____
 If you have answered yes to either of the above questions, please list the date of the occurrence: _____

REFERRING DOCTOR INFORMATION

Name of Referring Doctor: _____
 Address of Referring Doctor: _____
 Tel. #: () _____
 Primary Care Doctor, *(if different from Referring Doctor)*: _____
 Address of Primary Care Doctor: _____
 Tel. #: () _____

Date of Injury: / / _____
 Describe Accident: _____

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS/ AUTHORIZATION TO RELEASE MEDICAL INFORMATION/ CONSENT TO TREATMENT

I hereby assign all medical benefits to which I am entitled to Frederick Sport and Spine Clinic, Inc., for services rendered by Frederick Sport and Spine Clinic, Inc. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Frederick Sport and Spine Clinic, Inc., as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

I hereby authorize the release of any pertinent information to my insurance company and any other doctors involved in my case. **Additionally, I specifically authorize Frederick Sport and Spine Clinic to release information from my medical record to; _____ . (i.e. Spouse, Parent, Guardian, other).**

I understand that my account balance is due in full upon receipt of my billing statement. If my account becomes assigned to a collection agency, I agree to pay 25 percent collection agency fees, court costs, and attorney fees. I understand that all accounts with a balance over 30 days will be assessed a 1.5 percent interest per month on the unpaid balance. All co-pays are due at the time of service. If we must send you a billing statement, a \$25.00 *per statement* billing fee will be assessed.

SIGNATURE (Patient): _____ DATE: _____

SIGNATURE (Guarantor): _____ DATE: _____