



Spine & Sport

# PATIENT REGISTRATION

<b>OFFICE USE ONLY:</b>
DATE OF REFERRAL: _____
DIAGNOSIS: _____
EVAL DATE: _____

NAME: \_\_\_\_\_

SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DRIVERS LICENSE #: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

In an emergency, who should we contact?

EMAIL: \_\_\_\_\_

NAME: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

SPOUSE  
 PARENT/GUARDIAN

PHONE: \_\_\_\_\_ RELATION:  FRIEND

WORK PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ SEX: MALE FEMALE  
(circle one)

REFERRING PHYSICIAN: \_\_\_\_\_

Please describe your injury/condition (circle one):

WORK-RELATED      AUTO ACCIDENT      PERSONAL INJURY LIEN      NONE OF THESE

DATE OF INJURY: \_\_\_\_\_ or  No injury date

Are you represented by an attorney for this injury? YES NO  
(circle one)

If YES, please list the name of your attorney: \_\_\_\_\_

Please give us all pertinent information regarding your insurance coverage for this case. If you have more than one carrier, please give us information for both carriers. Please show all numbers on your card(s). We will need copies of all applicable insurance cards, as well. Thank you for your assistance.

PRIMARY INSURANCE: \_\_\_\_\_ or  DO NOT BILL INSURANCE

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_

INSURED NAME (As it appears on your insurance card): \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ or  NO SECONDARY INSURANCE

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_

INSURED NAME (As it appears on your insurance card): \_\_\_\_\_

**PLEASE READ THE OTHER SIDE AND SIGN YOUR NAME ♦ THANK YOU**

## Spine & Sport

### AUTHORIZATION FOR OUTPATIENT TREATMENT

I have been informed of the treatment considered necessary and that the treatment and procedures will be performed by appropriately licensed physical therapists, occupational therapists, chiropractors, athletic trainers, physical therapy assistants, and exercise physiologists employed by Spine & Sport. Authorization is hereby granted for such treatment and procedures as prescribed by my physician, or directed under California "Direct Access".

I certify that the information provided to Spine & Sport by me is correct, and I accept full responsibility for all charges\*. I hereby assign and authorize payment directly to the above named clinic of all applicable insurance benefits. If my current policy prohibits direct payment to Spine & Sport, I hereby instruct and direct the Spine & Sport to bill me directly for the insurance payments made to me. I understand that I am responsible for any balance after insurance payment, including all costs incurred in collecting the balance if the account becomes delinquent, such as court costs, attorney's fees and/or collection agency commissions or charges.

\*Patients with valid workers' compensation claims are not responsible for treatment charges.

### MEDICAL RECORDS AUTHORIZATION

Spine & Sport is hereby authorized to release information pertinent to my treatment to any doctor, insurer, compensation carrier, attorney or other agency legally involved with my case (proof of relationship will be confirmed).

### MEDICARE PATIENTS

I certify that the information provided to Spine & Sport by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

I authorize Spine & Sport to initiate a complaint to the Insurance Commissioner for any reason on my behalf. A photocopy of this assignment shall be considered as effective and valid as an original.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

As parent or legal guardian, I have read, understand, and agree with all items stated above and hereby authorized Spine & Sport to administer physical medicine treatment as prescribed to \_\_\_\_\_.

Patient Name

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date