Frederick Sport and Spine Clinic

PATIENT INFORMATION

Name:

Date of Birth: / /	Sex: Female Male
Address:	
Home Telephone Number:	Cell Phone Number:
Email Address:	
Guarantor's Full Name (if different from patient):	
Guarantor's Date of Birth: / /	
Guarantor's Address:	
Guarantor's Telephone Number:	
Spouse's Full Name:	Spouse's Date of Birth: / /
Patient's Employer and Address:	
Patient's Position Title:	Patient's Work Phone:

Primary Insurance Carrier:	Employer:
Name of Subscriber:	Subscriber Date of Birth: / /
Policy #/Member ID:	Group #:

Are your symptoms the result of an occurrence at work?	Yes	No
Are your symptoms the result of an automotive incident:	Yes	No
If yes to either question above please indicate date of occurrence:		

Name of Referring Doctor:	Phone:
Address:	
Name of Primary Care Doctor:	Phone:
Address:	

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 and authorize release of all information necessary to secure the payment of said benefits. A copy of this agreement 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 doctors involved in my case. I specifically authorize Frederick Sport and Spine Clinic to release information from my medical record to

_____. Relationship:_____.

I understand that my account balance is due in full upon receipt of my billing statement. I have read and understand the credit card agreement. If my account becomes assigned to a collection agency, I agree to pay 25% collection agency fees, court costs, and attorney fees. I understand that all accounts with a balance over 30 days will be assessed 1.5% interest per month on the unpaid balance. All co-pays are due at the time of service.

Signature (patient): _____ Date: _____

Signature (guarantor):_____ Date: _____