

# COLLIER SPINE INSTITUTE

## PATIENT REGISTRATION

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Street Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone No.: \_\_\_\_\_ Email Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_

Employer Address: \_\_\_\_\_

### *If Married Please Answer the Following:*

Spouse's Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Employer's Phone No.: \_\_\_\_\_

Spouse's Employer's Address: \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance Carrier: \_\_\_\_\_  Auto  Worker's Comp  Other: \_\_\_\_\_

Secondary Insurance Carrier(s): \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber I.D. #: \_\_\_\_\_ Subscriber DOB \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ Patient Relationship to Insured:  Self  Spouse  Other: \_\_\_\_\_

### ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I authorize COLLIER SPINE INSTITUTE to release information or copies of all medical records, including those that may contain information related to **HIV/AIDS, sexually transmitted diseases, mental health (excluding physcotherapy notes maintained separately from my medical record), alcohol or substance abuse, and genetic testing**, which are contained in my patient file to any third party payors or their representatives for the purpose of obtaining payment for the services rendered by COLLIER SPINE INSTITUTE. I understand I am responsible for my bills including any portion of my bill not covered or reimbursed by my insurance company/companies. I authorize COLLIER SPINE INSTITUTE to act as my agent to help assure payment from my insurance companies and request and assign payment directly to COLLIER SPINE INSTITUTE by all insurance carriers with whom I have coverage or from whom benefits are or may become payable to me including settlements or judgments flowing from incidents for which I may receive treatment. If collection action is necessary, I agree to pay all costs of collection, including reasonable attorney's fees, court costs and collection agency fees associated with the collection process.

**FOR MEDICARE PATIENTS.** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to COLLIER SPINE INSTITUTE for any services furnished me by COLLIER SPINE INSTITUTE. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I agree to execute such forms and documents as may be necessary to apply for and obtain payment.

**FOR MEDICAID PATIENTS.** I certify that I am a recipient of the Medicaid program, Title XIX, and request that payment of authorized benefits be made on my behalf. I authorize COLLIER SPINE INSTITUTE to make available to the Florida Department of Children and Family Services any requested information concerning medical insurance and financial records related to my treatment. I hereby certify all health insurance shall be assigned to COLLIER SPINE INSTITUTE.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### CONSENT FOR TREATMENT

**CONSENT FOR TREATMENT:** I, the undersigned, whose name appears above, hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the attending physician.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the COLLIER SPINE INSTITUTE Notice of Privacy Practices as required by Federal Law.

\_\_\_\_\_  
Patient/Personal Representative Signature Description of Personal Representative's Authority Date

If not signed, reason Patient/Personal Representative failed to sign \_\_\_\_\_

Staff Signature \_\_\_\_\_