Spinal Balance

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TODAYS DATE	REFERRED BY	S	M	W	D	SEP

PATIENT'S NAME		
ADDRESS		ZIP CODE
HOME PHONE	SOCIAL SECURITY #	BIRTH DATE	☐ MALE ☐ FEMALE
PATIENT'S EMPLOYER	BUSINESS ADDRESS	
OCCUPATION		BUSINESS PHONE
NAME OF SPOUSE	SPOUSE'S EMPLOYER	
BUSINESS ADDRESS	OCCUPATION	BUSINESS PHONE
PERSON TO NOTIFY IN CASE OF EMERGENCY	RELATIONSHIP	PHONE #
KNOWN ALLERGIES TO MEDICATION		

Primary Insurance:	Subscriber:
ID#:	Grp #:
Address:	
Other insurance:	Subscriber:
ID#:	Grp #:
Address:	
Liability: (auto accident) Yes_____No______	Date of injury:

WE DO NOT RECOGNIZE THIRD PARTY LIABILITY: THEREFORE, IF YOU WERE INJURED IN AN ACCIDENT AND EXPECT TO COLLECT DAMAGES FROM A NEGLIGENT PARTY, YOU WILL BE EXPECTED TO PAY YOUR BILL IN FULL AT TIME OF TREATMENT.

WORKMAN'S COMPENSATION INJUERD ON JOB? Yes_____No______	DATE OF ACCIDENT	CLAIM NUMBER	EMPLOYER NOTIFIED? Yes_____No______
COMPENSATION CARRIER	ADDRESS OF CARRIER		

Patient Authorization and Insurance Authorization Assignment

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.

I hereby authorize Vincent Romviel to furnish information to insurance carriers concerning my illness and treatments and and I hereby assign the physical therapist all payments for medical services rendered to me or my dependants. I understand that I am responsible for any balance not covered.

Signature:____ Date:______________________