

Welcome

Thank you for selecting our healthcare team! Colorado Spine Therapy, LLC, is committed to excellence in serving the health needs of the community. We are dedicated to giving each Patient a personal service that they can rely on and trust. To help us meet your needs please fill out this form completely. If you have any questions or need help, please ask- we will be happy to assist you.

For office
use only

Acct
Type _____

DX
Code _____

PT/Provider

INTAKE
COMPLETE
D BY

DATE:

Patient Information

Name Last _____ First _____ MI _____ Date _____

Current address _____

City _____ State _____ Zip _____

LOCAL Phone H _____ W _____ Other _____

Male Female Student Single Married Divorced Widowed Separated

Date of Birth: month _____ day _____ year _____

Permanent Address _____ Phone _____

City _____ State, _____ Zip _____

Employer _____ Occupation _____

Employer address _____

City _____ State _____ Zip _____

General information

Referring Doctor _____ Family Doctor _____

Description of Problem _____ Date of Onset _____

Was there an Accident? Auto _____ Work _____ Other _____ Claim Number _____

Adjuster _____ Adjusters Phone Number _____

Have you had Surgery? Y ___ N ___ If yes when? _____ Surgeon _____

Responsible party

Who is responsible for the account?

Name Last _____ First _____ MI _____ Relationship to Patient _____

Address _____

City _____ State _____ Zip _____

Social Security Number _____ Insurance ID number _____

Male Female Single Married Divorced Widowed Separated

Date of Birth: month _____ day _____ year _____ Drivers License _____

Employer _____ Occupation _____

Home phone _____ Work Phone _____

Insurance Company _____ Insurance Phone _____

Plan Number _____ Is There Secondary Insurance? Y ___ N ___

Medical Release of Information: I authorize the release of any medical information necessary to process this claim.

Signature _____ Date _____

Assignment of Benefits: I hereby assign payment directly to **Colorado Spine Therapy LLC**, who represents this clinic to Payor Groups. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered.

Signature _____ Date _____

Unaccompanied Minors

The parents (or guardians) are responsible for full payment at the initial visit. Subsequent charges may be billed to the insurance company, but co-payments, deductibles, and non-covered amounts must accompany the minor at each visit.