Robertson Spinal Rehab Associates
Out of injury, back to life

Patient Registration Information

Please print and complete all sections below.

Account #:_____

Is your condition a result of a **work injury**? YES NO **Auto accident**? YES NO Date of injury:_____

Patient Personal Information

Marital Status: Single _____Married _____Divorced _____Widow_____ Sex: M _____ F _____

Name:_____ _____ _____
(Last Name) (First Name) (Middle Initial)

Street Address:_____Apt #:_____

City:_____ State: _____ Zip:_____

Mailing Address (if different from street address):_____

City:_____ State:_____ Zip:_____

Home Phone :(_____)_____-_____Cell Phone :(_____)_____-_____Preferred method of Contact: Home or Cell

Email:_____ Date of Birth:___/_____/____ Age:_____ Nickname :_____

Emergency Contact:_____ Relationship:_____ Primary Phone:(_____)_____-_____

Patient Primary Insurance

Please provide insurance card.

Primary Insurance Company's Name:_____

Insurance ID#:_____ Group #:_____ Insured: SELF / SPOUSE /

***** Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any co-insurance, deductible amount or any other balance not paid for by your insurance. *** _____ Patient's Initials**

Referred by:_____ If referred by a friend, may we thank them? YES NO

Assignment of Benefits * Financial Agreement

I hear by authorize assignment of my insurance rights and benefits directly to provider for services rendered (if offered at this office.)

— We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

— Our policy requires payment in full for all services rendered at time of visit, unless other arrangements have been made with business manager. If account is not paid within 90 days of date of service and no financial arrangements have been made, you will be responsible for any expenses and attorney fees incurred in collecting your account.

— I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

— I understand the above information and guarantee this form was completed correctly to best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Date: _____/_____/_____ Your Signature:_____

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