

**PATIENT INFORMATION**

First Name	Middle Initial	Last Name	/ /	M / F
		Date of Birth	Sex (circle one)	
Street Address		City	State	Zip Code
( )	( )	SS # or Last 4		Marital Status
Home Phone		Work/Cell Phone		
Referring Physician	( )	Primary Care Physician	( )	
		Phone Number	Phone Number	
Name of Nearest Relative Not Living With You	Relationship	( )	( )	
		Home Phone	Work/Cell Phone	

**Patient Email Address**

**INDIVIDUAL RESPONSIBLE FOR PAYMENT**

First Name	Middle Initial	Last Name	/ /	M / F
		Date of Birth	Sex (circle one)	
Street Address		City	State	Zip Code
( )	( )	Social Security Number		Relationship to Patient
Home Phone		Work/Cell Phone		
Employer		Employer Address		

**INSURANCE INFORMATION**

**Is this part of an Auto or Workman's Compensation Claim?**

Primary Insurance Company Name		Secondary Insurance Company Name	
Policy ID #	Group #	Policy ID #	Group #
Name of Policy Holder	Relationship to Insured	Name of Policy Holder	Relationship to Insured
/ /	Policy Holder SSN	/ /	Policy Holder SSN
Policy Holder Date of Birth		Policy Holder Date of Birth	

**\*No Show Policy – Our office requires 24 hour notice for appointment cancellations or a no-show fee will be applied to your statement.**

**\*Medication refill requests require 72 hours for completion. Please have your pharmacy send our office a fax request or leave a message with our pharmacy line for your refill needs. Our providers will not provide refill medications on Fridays or on the weekend.**

**ASSIGNMENT OF BENEFITS AND IN/OUT OF NETWORK ACKNOWLEDGEMENT**

I understand that I am responsible for payment in full of all charges. I authorize payment of benefits from my insurance company be paid directly to the provider. I also authorize my providers' office to release to my insurance company any and all information necessary for the processing of insurance claims. I acknowledge that some Colorado Comprehensive Spine Institute, LLC providers MAY NOT be in network with my insurance and I may be responsible for in and out of network deductibles and/or co-insurance. I understand that I am responsible for reasonable attorney fees and courts costs if placed into collection.

**SIGNATURE (REQUIRED) \_\_\_\_\_ DATE \_\_\_\_\_**