PATIENT DEMOGRAPHICS

Date: _____._____._____

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PATIENT DATA:

Patient Name: Mr. Mrs. Ms. _____
First MI Last

DOB: _____._____._____ **SSN:** _____._____._____

Address: _____
Street City State Zip Code

Home #: _____._____._____ **Cell #:** _____._____._____ **Email**: _____

Employer: _____ **Work #:** _____._____._____

Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Widow **Name of Spouse:** _____

Race: ❍ White ❍Asian ❍American Indian ❍African American ❍Pacific Islander ❍ Other _____

Ethnicity: ❍ Hispanic/Latino ❍ Not Hispanic/Latino

Preferred Language: ❍ English ❍ Spanish ❍ Other _____

Primary Care Physician: _____ **Referring Physician:** _____

Preferred Pharmacy: Local- _____ **Mail Order** _____

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INSURANCE DATA:

1° Insurance: _____ **Tel #:** _____._____._____

Subscriber Name: Mr. Mrs. Ms. _____ DOB: _____._____._____
First MI Last

Plan/ID #: _____ **Group #:** _____ **Copay:** $_____.00

2° Insurance: _____ **Tel #:** _____._____._____

Subscriber Name: Mr. Mrs. Ms. _____ DOB: _____._____._____
First MI Last

Plan/ID #: _____ **Group #:** _____ **Copay:** $_____.00

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ATTORNEY/WORKERS' COMPENSATION DATA:

Carrier/Attorney Name: _____ **Tel #:** _____._____._____

Case Manager(if WC): _____ **Tel #:** _____._____._____

Address: _____
Street City State Zip Code

Case #: _____ **Injury Date:** _____._____._____

Employer of Record: _____

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FINANCIAL CONTRACT

I fully understand and agree to be bound by the policy that financial payment is due at the time of service by Virginia Interventional Spine Associates. I fully acknowledge that I have been given ample opportunity to discuss this policy in full with all of my questions answered to my complete satisfaction by the staff of Virginia Interventional Spine Associates such that I fully accept full financial responsibility for all charges for services provided to me by Virginia Interventional Spine Associates not covered by my healthcare insurance. I fully assign directly to Virginia Interventional Spine Associates all benefits, otherwise payable to me for services provided to me by Virginia Interventional Spine Associates. I fully authorize Virginia Interventional Spine Associates to release all information necessary to secure the payment of benefits to Virginia Interventional Spine Associates. I fully authorize the use of my signature below on all manual or electronic insurance submissions. Certain test(s) may be ordered by Virginia Interventional Spine Associates; in which, I fully agree to be financially responsible for these services should they be considered "non-covered" or "not medically-indicated" by my healthcare insurance. If my treatment is involved with a work-related injury and Virginia Interventional Spine Associates is to file Workmans' Compensation claims on my behalf, I fully authorize Virginia Interventional Spine Associates to discuss the plan of treatment, care and appointment information with the claims payers or caseworkers. Should my account become delinquent >30 days, I fully authorize an additional 1.5% finance charge be added monthly to my account until collection by Virginia Interventional Spine Associates. In the event that my delinquent account is forwarded to an attorney/agent for collection by Virginia Interventional Spine Associates, I fully authorize an additional payment by me equaling 30% of the highest outstanding balance as reasonable fees for an attorney/agent to collect my delinquent account for the services provided to me by Virginia Interventional Spine Associates.

_____ _____ _____._____._____
Patient or Representative Signature Witness Signature Date

_____ _____
Print Name Relationship to Patient