Dietze and Logan Spine Specialists
Registration Form

Name_____ Home Phone_____

Cell Phone_____ Address_____

City_____ State_____ Zipcode_____

DOB_____ Sex □M □F Age_____ SS#_____

Employer_____ Work Phone_____ Occupation_____

Email Address_____ Pharmacy _____

Referring Physician_____ Primary Care Physician _____

Is patient's condition related to: Work Injury? _____ Injury Date_____
Auto Accident? _____ Injury Date_____
Other Accident?_____ Injury Date_____

Is there an attorney involved in your case? □Yes □No If yes, name_____

Insurance Information

Primary Insurance_____ ID#_____

Policy Holder Name_____ SS#_____

DOB_____ Insured Employer_____

Secondary Insurance_____ ID#_____

Policy Holder Name_____ SS#_____

DOB _____ Insured Employer_____

If Patient Is A Minor

Father's Name_____ Mother's Name_____

DOB_____ Wk Phone_____ DOB_____ Wk Phone_____

SS#_____ SS#_____

IN CASE OF EMERGENCY CONTACT:

Name_____ Phone_____ Relationship_____

I am giving permission for Dietze and Logan Spine Specialist to disclose my protected health information to the following:
(example: Spouse, child, parent)

Name_____ Relationship_____

Name_____ Relationship_____

CONSENT FOR TREATMENT: I do hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As outlined in our notice, the terms of our notice may change. If our notice is changed or modified, you may obtain a revised copy by request from the receptionist.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to treatment and our use and disclosure of protected health information about you for treatment, payment and health care options. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1)Any and all records, whether oral or in electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2)A photocopy or fax of this consent is as valid as this original.
3)I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked in writing by me.

_____ _____

Signature of Patient or Guardian Date

ASSIGNMENT OF BENEFITS: I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to Dietze and Logan Spine Specialist, Freedom Spine and Spine Innovations.

Signature_____ Date_____

FINANCIAL POLICY

- Insurance **copay's** are due upon sign in. Full payment is due when service is rendered.
- As a courtesy, we will file your insurance claim for you if you assign benefits to Dietze and Logan Spine Specialists. (Agree to pay us directly.)
- If your insurance company does not pay us within a reasonable length of time (60 days), we must look to you for payment.
- **If my account becomes assigned to a collection agency, I agree to pay any collection agency fees, court costs and attorney fees.**
- All health plans are not the same and do not cover the same services. In the event your plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the financial policy of Dietze and Logan Spine Specialist and agree to be bound by these terms. I also understand and agree that such terms may be amended from time to time by Dietze and Logan Spine Specialists.

_____ _____

Signature of Patient or Guardian Date