

**FINANCIAL RESPONSIBILITY AND INSURANCE AUTHORIZATION**

Full Name \_\_\_\_\_ Social Security # \_\_\_\_\_

**Is injury work related?** Yes\_\_ No\_\_ If yes, claim # \_\_\_\_\_

Date of Injury \_\_\_\_\_ Employer \_\_\_\_\_

Is your claim open Yes\_\_ No\_\_

If Self Insured Worker’s Compensation please provide the following:

Insurance Company \_\_\_\_\_ Claim Manager \_\_\_\_\_

Billing Address \_\_\_\_\_ Phone # \_\_\_\_\_

**Is injury auto accident related?** Yes\_\_ No\_\_ Is your claim open? Yes\_\_ No\_\_

If yes, Insurance Carrier \_\_\_\_\_

Billing Address \_\_\_\_\_

Adjustor Name \_\_\_\_\_ Phone number \_\_\_\_\_

Date of Accident \_\_\_\_\_ Claim Number \_\_\_\_\_

**Primary Health Insurance** \_\_\_\_\_

**Secondary Health Insurance** (if applicable) \_\_\_\_\_

Is your insurance company an HMO or Medicare Replacement /Advantage Plan? Yes\_\_ No\_\_

**Primary Care Provider?** (First and last name) \_\_\_\_\_

Phone number \_\_\_\_\_

- **PLEASE BRING ALL INSURANCE CARDS TO YOUR APPOINTMENTS**
- **ALL CO-PAYMENTS AND DEPOSITS ARE DUE AT THE TIME OF APPOINTMENT**
- **IF YOU HAVE NO HEALTH INSURANCE TO BILL, YOU WILL BE REQUIRED TO MAKE A DEPOSIT OF \$150.00 ON YOUR 1<sup>ST</sup> VISIT. \$60.00 ON ALL FOLLOW-UP VISITS. (AUTO PIP/MEDPAY IS NOT CONSIDERED HEALTH INSURANCE)**

Spokane Brain and Spine relies on the insurance and billing information provided to us by you or your referring provider. In the event that this information is not accurate a cash deposit may be required, or your appointment may need to be rescheduled. After services are provided, we will submit our claim to your insurance carrier if applicable. In the event that payment is denied, the patient is responsible for full payment. All patient balances are due within 30 days of the statement date. It is the patient’s responsibility to contact the financial services department if this obligation cannot be met. We are committed to assisting our patients in meeting their financial responsibility, however if arrangements are not made we will utilize the services of the credit bureau or a collection agency. Any fees associated with the services of these companies are the responsibility of the patient.

I HAVE READ, COMPLETED AND FULLY UNDERSTAND THE INFORMATION ABOVE. I HEREBY AUTHORIZE PAYMENT OF MY INSURANCE BENEFITS DIRECTLY TO THE PHYSICIAN AND RELEASE OF ANY INFORMATION REQUIRED.

Signature \_\_\_\_\_ Date \_\_\_\_\_