COMMONWEALTH SPORT AND SPINE

PATIENT INFORMATION

Last Name	First Name		Middle Initial	Social Security Number
Sex: Male / Female	Prefix	Suffix	Date of Birth (month/day/year)	Student: No/ Full Time/ Part Time
Street Address	City/State		Zip Code	Emergency Contact/Relation to you:
Home Telephone	Work Phone		Cell. Phone	Email Address:
Race:	Marital Status: Single/Married/Divorced/ Widowed		School Name/Phone Number (if applicable)	Job Title
Assigned Preferred Provider (PCP)			Preferred Pharmacy Name/Phone Number	
Employer	Employer Address/Phone Number			

RESPONSIBLE PARTY/BILLING INFORMATION

Last Name	First Name	Middle Initial	Prefix	Suffix
Date of Birth	Sex: Male/ Female	Social Security #	Relationship to Patient:	
Street Address (if different from above)		City/State	Zip Code	
Home Telephone	Work Telephone	Employer Name	Job Title	
Employer	Employer Address			

PRIMARY INSURANCE INFORMATION

Policy #	Group #	Effective Date	Primary Insurance: Yes / No

Specialist Co-Pay $		Name of Insurance Company/Plan	
Insurance Co. Address		City/State	Insurance Co. Telephone
Insured's Name (Person whose insurance you are on):	Date of Birth	Home Telephone	Social Security Number
Insured's Employer	Address/State/Zip Code (if same as patient leave blank) :		Employer Telephone

SECONDARY INSURANCE INFORMATION

Policy #	Group #	Effective Date	
Office Co-Pay $	Specialist Co-Pay $	Name of Insurance Company/Plan	
Insurance Co. Address		City/State	Insurance Co. Telephone
Insured's Name	Date of Birth	Home Telephone	Social Security Number
Insured's Employer	Address/State/Zip Code (if same as patient leave blank) :		Employer Telephone

PATIENT AUTHORIZATION

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to Commonwealth Sport and Spine, LLC, or any of its affiliates or agents, lenders, or any third party servicer acting for CSS or any of its affiliates.

I agree to promptly pay for services rendered for me or the patient named above. If I fail to meet my financial commitment to Commonwealth Sport and Spine and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for any missed appointments of which I did not notify the medical office within a reasonable amount of time.

I hereby understand that with treatment at any Commonwealth Sport and Spine office I have given consent to testing and release of test results related to infection with human immunodeficiency virus or hepatitis B or C viruses, if in their opinion, an employee has suffered an exposure incident as a result of my treatment, as defined by the Centers for Disease Control and the Occupational Safety and Health Administration. I also understand I have consented to the release of such test results to the person who was exposed.

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Patient Signature /Date Print Patient Name